



MARY LANNING HEALTHCARE
JOB SHADOWING REQUEST

Applications must be received a minimum of 3 weeks prior to the requested date.

Name: _____ (Please Print)

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ School Phone: _____

High School: _____ Grade Level: Junior Senior

Address: _____

City: _____ State: _____ Zip: _____

Counselors Name: _____

Shadowing Date and Time Requested: _____

Shadowing Interest: _____ Nursing _____ Pharmacy
_____ Cardiopulmonary _____ Physical Therapy
_____ Laboratory _____ Other
_____ Radiology

Write a paragraph on the second page of this paper stating your reasons for requesting this job shadowing experience. Include what experiences you hope to gain and course objectives if applicable. (Required.)

PARENTAL CONSENT

I, _____ (parent/legal guardian) give my consent for _____ to participate in the Mary Lanning Memorial HealthCare Job Shadow Program and release the hospital of any liability while my son/daughter is on hospital grounds. In addition, I verify that my son / daughter has the following up to date Immunization's: Measles, Mumps & Rubella (MMR), Chicken Pox (Varicella) or history of the disease and Tetanus/Diphtheria.

Signature: _____ Date: _____

COUNSELOR RECOMMENDATION

Signature: _____ Date: _____

Please return this form to: Attn: Jodi Sowl BSN, RN / Dept. of Education
Mary Lanning Memorial HealthCare
715 North St. Joseph
Hastings, Nebraska 68901

