

TRINITY HEALTH SYSTEM  
STUDENT JOB-SHADOWING  
PROGRAM APPLICATION

Name \_\_\_\_\_ Date \_\_\_\_\_  
(last) (first) (middle)  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Birth Date \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
If employed, name of firm \_\_\_\_\_ Phone \_\_\_\_\_  
Contact in case of emergency \_\_\_\_\_

\_\_\_\_\_  
(name) (relationship) (home phone) (work phone)  
Why are you interest in participating in the shadowing program?  
\_\_\_\_\_  
\_\_\_\_\_

High School/College attending \_\_\_\_\_

Signature \_\_\_\_\_

Signature \_\_\_\_\_  
(Parent signature if under 18 years of age)

**CONFIDENTIALITY STATEMENT**

I understand and agree that in the job-shadowing program at Trinity Health System, I must hold in strictest confidence any observations I may make or hear regarding clients, client families, of staff.

I understand that intentional or involuntary violation of confidentiality may result in disciplinary action, including termination, by Trinity Health System and/or possible legal action (i.e., clients, families of clients, ect.)

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Hospital Department \_\_\_\_\_  
Date \_\_\_\_\_ Hours Shadowed \_\_\_\_\_

Department Employee Signature \_\_\_\_\_

*When the individual has completed the shadowing, please return this to the Volunteer Office at the East Campus.*