Bassett Healthcare Network
Bassett Medical Center

Job Shadow / Internship Application

Last Name	First		Middle Initial
Street Address	City	State	Zip
Email Address		Cell Phone	Home Phone
Grade/Year in College	School/College	Date of Birth	
Occupation / Department you are interested in for your Educational Experience:			
Is this a Credit based internship: Yes No If yes, how many hours are required: Requested dates for your Educational Experience:			
Name of Institution requesting the Internship:			
Contact Information for Institution:			

Your Educational Experience will be arranged for a time that is convenient for the person you will be shadowing and be during normal business hours. Signing this application in the space provided below indicates that you fully understand the following statements.

____ *I agree to provide or arrange transportation to and from the job site*

____ *I promise to abide by all hospital policies that are included in the employee handbook while on my job shadow.*

____ *I will consider all information confidential, which I may gain, either directly or indirectly, concerning a patient.*

Signature of Applicant: _____ *Date:* _____

If under the age of 18 Parent or Guardian must support and grant permission for their son/daughter to participate in the Job Shadow program.

Signature of Parent or Guardian: _____ *Date:* _____