



Choosing Health

Northeastern Vermont Regional Hospital

APPLICATION FOR JOB SHADOW EXPERIENCE.

Mr/Mrs./Ms: _____

Last Name

First

Address (actual location) _____

Mailing Address _____ E-Mail _____ Phone# _____

Education/Special Training _____

Business Experience _____

Volunteer Experience _____

Clubs/Organization Affiliations _____

Foreign Language (fluently) _____

How did you hear about NVRH Job Shadow Program? _____

Are you legally eligible for employment in the United States? **Yes No**

Are there circumstances that might affect your ability to perform job-related tasks safely? **Yes No**

If "yes" please give details _____

In an emergency notify _____ Relationship: _____ Phone _____

List two personal references (Name/Address/Phone)

Your reason(s) for entering shadow program: _____

PLEASE READ AND SIGN THIS PAGE. THANK YOU

I understand that any falsification, misrepresentation, or omission of necessary information contained in this application will result in the cancellation of this application, and if I am already acting as a NVRH Shadow Experience participant may be cause for immediate dismissal from the program.

I hereby grant permission to Northeastern Vermont Regional Hospital to investigate my references and background. I also release NVRH from any and all liability from such investigation.

I agree to conform to the rules and regulations of NVRH Volunteer Services Department for the NVRH Shadow program.

Date: _____

Signature: _____