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** **N o**

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: _____