Revere Health
Your health above all else

Shadowing Application

Name _____

Email Address _____ Phone # _____

_____

Address City State Zip

Are you age 18 or older? ☐Y ☐N

School currently enrolled with and degree being pursued?

_____

_____

Which physician(s) and departments would you like to work with?

_____

_____

Shadowing: What dates and times are you available?

_____

_____

What are your goals for this experience?

_____

_____

What are your career plans and goals?

_____

_____

☐ I understand that I am expected to arrive **five minutes early** for all shadowing appointments, **dress and act professionally** and turn off all cell phones or electronic devices during the shadowing experience. I will give no less than 48 hours' notice if I will be unable to attend my scheduled appointment. Violation of these rules may result in the cancellation of all future shadowing appointments.

Signature_____ Date: _____

FOR OFFICE USE ONLY

Physician _____Date:_____ Physician _____Date:_____ Physician _____Date:_____	Set by Department _____ Department _____ Date