DENVER HEALTH

Level One Care for ALL

Job Shadow Application

Thank you for your interest in Denver Health! Please complete the following information to participate in the job shadowing program.

Today's Date: _____

Name: _____
Last First M.I.

Address: _____ City _____ State ____ ZIP _____

Home Phone _____ Office/Cell Phone _____

E-mail address _____

If under 18 years of age: Date of Birth _____ Age _____

Parent/Guardian Name: _____
Last First M.I.

Emergency Contact

Name _____Relationship _____

Address _____ Phone _____

Present Employer (if applicable)

Company/Organization Name _____

Address _____

Education Status

List highest level of education completed, school, dates, and course of study: _____
_____

Are you currently enrolled in school? No □ Yes □ Where? _____

Limitations

Do you have a medical condition or disability that requires a special accommodation? Yes □ No □
Please specify so that Denver Health can ensure an appropriate accommodation is provided:
_____

Assignment Request

Area of 1st choice _____ 2nd choice _____

Which specific provider will you be shadowing under? _____

NOTE: Denver Health will not find a provider for you to shadow. You must have received permission from a specific provider to shadow prior to submitting this application.

Is there a specific date or timeline in which the Job Shadow must be completed? _____

Referred to Job Shadow program by: _____

Please explain why you want to shadow a health professional at Denver Health:_____

_____

Is there any other information we should know? _____

Shadow Applicant's Signature: _____ Date: _____

Please return this application to:
Denver Health
Attn: HR Career Center/Job Shadowing
660 Bannock, MC 1918
Denver, CO 80204
FAX 303-602-2669

To be completed by Denver Health:

Department Assignment _____

Assigned Host(s) _____

Shadow Date(s) _____

Signature: _____Date: _____ __