# Job Shadow Program Application

## Your Information:

Name: _____ Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

School: _____ DOB: _____

Emergency Contact Name: _____ Phone: _____

The department you would like to shadow: _____

Dates and times you are available to shadow: _____

_____

*By my signature below, I confirm that I have read, understand, and agree to adhere to the conditions and policies of a Madison Regional Health System job shadow experience. I hereby agree that I will not disclose to anyone information concerning patients and patients' family members which I may acquire during the observation period.*

_____ _____

Shadow participant signature Date

_____ _____

Parent/Guardian signature (if under Age 18) Date

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**Choose one of the options below to return your application!**

1. Email: Email your application to info@madisonhospital.com
2. Drop Off: Drop off your application at the front desk at Madison Regional Health System.
3. Mail: Mail your application to:

   Madison Regional Health System
   Attn: Director of Quality & Safety
   323 SW 10th Street
   Madison, SD 57042

Please note: We will make every effort to reply to your request within 30 days.