Student Shadow Program

Today's Date: _____

Student Name: _____

Phone Number: _____

Address: _____

University or College: _____ Campus: _____

Department Where You Will Be Shadowing: _____

Dates/Times Scheduled for Shadow (16 Hour Limit):

_____

Employee You Are Shadowing: _____

Emergency Contact Name: _____

Emergency Contact Number: _____

Confidentiality Form Signed and Attached ☐ YES ☐ NO

Criminal Background Record Results Attached ☐ YES ☐ NO

Drug Screen Results Attached ☐ YES ☐ NO

Immunization Record with PPD Results Attached ☐ YES ☐ NO

RETURN FORMS AND DOCUMENTATION TO:
Bayhealth Medical Center, Inc.
c/o Andrea McNatt, Education Department
640 South State Street
Dover, DE 19901

Phone: 302-744-6722
Fax: 302-730-3047