



Mid-State Health Center Job Shadowing Registration - Adult

Student Information (Please print)

Name: _____ Date of Birth: _____
 Email: _____ Phone: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Emergency Contact: _____ Phone: _____

College Information

School Name: _____ Contact Person: _____
 Phone: _____ E-Mail: _____
 Address: _____
 City: _____ State: _____ Zip: _____

Area of Preference:

- | | | |
|--|---|---|
| <input type="checkbox"/> Nursing
<input type="checkbox"/> Internal Medicine
<input type="checkbox"/> Family Practice
<input type="checkbox"/> Billing/ Coding | <input type="checkbox"/> Radiology
<input type="checkbox"/> Laboratory
<input type="checkbox"/> Behavioral Health | <input type="checkbox"/> Medical Assistant
<input type="checkbox"/> Medical Records
<input type="checkbox"/> Dental
<input type="checkbox"/> Other _____ |
|--|---|---|

Please describe your interests in healthcare, and why you want to job shadow.

Preferred date(s) you would like to observe? (#1, #2 & #3)

of hours: _____

- | | | |
|---|---|--|
| <input type="checkbox"/> January _____
<input type="checkbox"/> February _____
<input type="checkbox"/> March _____
<input type="checkbox"/> April _____ | <input type="checkbox"/> May _____
<input type="checkbox"/> June _____
<input type="checkbox"/> July _____
<input type="checkbox"/> August _____ | <input type="checkbox"/> September _____
<input type="checkbox"/> October _____
<input type="checkbox"/> November _____
<input type="checkbox"/> December _____ |
|---|---|--|

Immunizations (List dates below and attach record to form)

- | | | |
|--|--|---|
| <input type="checkbox"/> Tdap (Tetanus, Diphtheria, Pertussis)
Date: _____
<input type="checkbox"/> MMR (Measles, Mumps & Rubella)
1 st : _____
2 nd : _____ | <input type="checkbox"/> Hepatitis B
1 st : _____
2 nd : _____
3 rd : _____ | <input type="checkbox"/> Influenza (Flu Shot)
Date: _____
<input type="checkbox"/> COVID Vaccine
Date: _____ |
|--|--|---|

Return the following:

- Job Shadow Registration
- Commitment Statement
- Confidentiality Agreement
- Proof of Immunizations

Return to:

Human Resources – Mid-State Health Center
 101 Boulder Point Drive, Suite 1
 Plymouth, NH 03264
ttole@midstatehealth.org

Applicants with missing or incomplete forms will not be able to job shadow. All requests are assigned in the order in which they are received. You will be contacted via email with assigned observation date.