



Mid-State Health Center
Job Shadowing Registration – Minor

Student Information (Please print)		
Name: _____ DOB: _____		
Email: _____ Phone: _____		
Address: _____ City: _____ State: _____ Zip: _____		
School/ Facility Information		
School Name: _____ Contact Person: _____		
Phone: _____ E-Mail: _____ Address: _____		
City: _____ State: _____ Zip: _____		
Area of Preference:		
<input type="checkbox"/> Nursing	<input type="checkbox"/> Radiology	<input type="checkbox"/> Medical Assistant
<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Laboratory	<input type="checkbox"/> Medical Records
<input type="checkbox"/> Family Practice	<input type="checkbox"/> Behavioral Health	<input type="checkbox"/> Dental
<input type="checkbox"/> Billing/ Coding		<input type="checkbox"/> Other _____
Please describe your interests in healthcare/ post-secondary plans, and why you want to job shadow.		
Preferred date(s) you would like to observe? (#1, #2 & #3) # of hours required: _____		
<input type="checkbox"/> January _____	<input type="checkbox"/> May _____	<input type="checkbox"/> September _____
<input type="checkbox"/> February _____	<input type="checkbox"/> June _____	<input type="checkbox"/> October _____
<input type="checkbox"/> March _____	<input type="checkbox"/> July _____	<input type="checkbox"/> November _____
<input type="checkbox"/> April _____	<input type="checkbox"/> August _____	<input type="checkbox"/> December _____
Immunizations (List dates below and attach record to form)		
<input type="checkbox"/> Tdap (Tetanus, Diphtheria, Pertussis) Date: _____	<input type="checkbox"/> Hepatitis B 1 st : _____ 2 nd : _____ 3 rd : _____	<input type="checkbox"/> Influenza (Flu Shot) Date: _____
<input type="checkbox"/> MMR (Measles, Mumps & Rubella) 1 st : _____ 2 nd : _____		<input type="checkbox"/> COVID Vaccine Date: _____
Parent/ Guardian Permission		
I give permission for my child _____, (a minor) to participate in an observational experience at Mid-State Health Center. I release Mid-State Health Center from all claims that may arise from this observational experience. I understand this is an observational experience only and my child will not give health care or advice to patient(s) nor be financially compensated for their time at Mid-State Health Center.		
Parent Name (Print) _____ Signature: _____		
Home/ Cell Phone: _____ Date: _____		
Teacher/ Counselor Information		
Please enter student information and sign and date this section. The signature constitutes school approval to release the student to participate in this experience. This is not required during summer break.		
Teacher/ Counselor (Print): _____ Signature: _____		
Phone: _____ Email: _____ Date: _____		
Return the following:		Return to:
<input type="checkbox"/> Job Shadow Registration <input type="checkbox"/> Commitment Statement <input type="checkbox"/> Confidentiality Agreement <input type="checkbox"/> Proof of Immunizations		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.		