



1401 West Pawnee St., Cleveland, OK 74020

918-358-2501 www.ClevelandAreaHospital.com

Student Shadowing Program Application

Name: _____

Phone: _____ Email: _____

Address: _____

Emergency Contact: _____ Phone: _____

School: _____ Year: _____

Recommended By: _____ Favorite Subject: _____

Please list any certifications/skills:

Do you have plans after High School? _____

What do you hope to gain from your shadowing experience? _____

I am interested in this/these career areas:

Nursing Radiology Respiratory Patient Access

Billing/Coding Physical Therapy Human Resources Family Practice Clinic

Marketing/Community Outreach Maintenance

Please identify what shifts/days you are available to shadow:

Experience: Please accurately list and briefly describe all prior and current internship, shadowing, research, and health care delivery experiences, including total hours for each:

Have you had the following?

Covid Vaccine

Flu shot

TB Test

Immunizations

Approved

Not Approved

Manager's Signature

Human Resource Signature