



Job Shadow Program Registration Form

Instructions: Please fax this completed form to (513) 803-6114. Thanks

Name: _____
Last First Middle

Date of Birth: _____ **Phone numbers:** (H) _____ (C) _____
(Month / Day / Year)

Home Address _____
Street City State Zip

School Currently Attending: _____

Current Grade Level (circle one): H.S. Junior H.S. Senior College Other

E-mail Address: _____
(Required - Please clearly indicate E-mail address)

Preferred Job Shadow Date: Please select a first, second, and third choice by circling a date on each line.

First Choice:	4/23/10	5/21/10	6/25/10	7/23/10	8/27/10	9/24/10	10/22/10	11/19/10	12/17/10
Second Choice:	4/23/10	5/21/10	6/25/10	7/23/10	8/27/10	9/24/10	10/22/10	11/19/10	12/17/10
Third Choice:	4/23/10	5/21/10	6/25/10	7/23/10	8/27/10	9/24/10	10/22/10	11/19/10	12/17/10

NOTE: Confirmation will occur 1-2 weeks prior to a scheduled event

Please indicate up to three (3) health professions you are interested in shadowing. Indicate your preference order by 1, 2, or 3.

- | | |
|---|--|
| <input type="checkbox"/> Audiologist | <input type="checkbox"/> Physician |
| <input type="checkbox"/> Health Unit Coordinator (HUC) | <input type="checkbox"/> Radiology Technician |
| <input type="checkbox"/> Registered Nurse | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Nutrition Therapist (Registered Dietitian) | <input type="checkbox"/> X-Ray / MRI |
| <input type="checkbox"/> Orthopedics | <input type="checkbox"/> Respiratory Therapist |
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Social Worker (Must be a college student) |
| <input type="checkbox"/> Pharmacist | <input type="checkbox"/> Speech Pathologist |
| <input type="checkbox"/> Physical Therapist | |

Have you previously participated in the Cincinnati Children's Job Shadow Program? Yes No

Please be sure to complete the next page.

