West Tennessee Healthcare
Job Shadow Application

Personal Information:

Name ____

Current Address ____

City, State, Zip ____

Phone ____

Email Address____

Are you under 18 years of age? ☐ **Yes** ☐ **No** **If yes, date of birth**___________

Emergency Contact __________________________________ **Phone** ____________

Signature ___________________________________ **Date** _____________________

Department Information:

In what area will you be observing i.e. radiology, physical therapy?

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Name of your contact in that area _______________________________________

For how many hours will you be observing? ________________________________

Thank you for choosing to job shadow at a West Tennessee Healthcare facility. You are required to complete a brief orientation on the Patient and System Confidentiality Policy of West Tennessee Healthcare as well as complete a brief training session on HIPAA (Health Information Portability and Accountability Act).

Return this application along with appropriate health screening documents to:

Consumer Support Services
West Tennessee Healthcare
620 Skyline Drive
Jackson, TN 38301

Fax to: 731-541-5168

PREFERRED - Email to: katie.chandler@wth.org