PENNSTATE HERSHEY
Milton S. Hershey Medical Center

Penn State Milton S. Hershey Medical Center

Penn State College Of Medicine

Application for Observation, Career Shadowing or Internship

For all Visitors & Students

Last Name: ______________________________ First Name: ______________________

Student's Date of Birth (mm/dd/yyyy): ___________ Age: _____ Date of application: ___________
(If student is under 18 years of age, parent or guardian must sign consent on page 2)

Home Address: ____

City: _____________________ State/Province: _______ Zip/Postal Code: ____________

Email address: ______________________________________

Home Phone: ( ) ________________________ Cell Phone: ( ) ___________________________

Student Grade/Year: _____________ School District: ______________________________

School/College: ____

School Contact: ____
Name Phone

Clinical or Research Area Requested:

Department/Profession you would like to observe: __________________________________

____
(Please include any special requests or personal contacts you have in the individual department/profession.)

Requested location (please check): ☐ Clinical ☐ Laboratory Research ☐ Both

Times and dates you are available to observe: ______________________________________

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If you currently have an Observation, Career Shadowing or Internship scheduled, provide the preceptor's name, department, site location, time/date: ______________________________________

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Desired goals or outcome of observation: ____

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Emergency Information

I hereby permit and authorize Penn State Milton S. Hershey Medical Center to perform any and all treatment, including but not limited to medical, dental and surgical, that may be necessary for I or my child during the course of my participation in the program for which I have obtained approval. The following information is being requested in order to be able to react appropriately in the event of an emergency concerning the student observer. Please provide any information which might be relevant in the case of an emergency. This information will be shared with those staff involved in the student observation.

Family Physician: ______________________________________ Phone: ____________________

______________________________________ ____________________

Emergency Contact Name (please print) Phone

Consent to Participate

I hereby grant/agree to participate (or allow my child to participate) in the Penn State HMC/COM Observation, Career Shadowing, Internship Programs. I certify that I/my child is at least 15 years of age.

I further hereby: ☐ grant permission ☐ decline permission

- interviews, tests, and questionnaires of or by student for program evaluation purposes
- publicity activities including interviews
- printed information
- still photographs/slides
- videotape recordings
- audiotape recordings
- internet usage

to release the above information for purposes of publication in newspapers, magazines, publications of Penn State Milton S. Hershey Medical Center and of the Penn State College of Medicine, other print media, or broadcasting by means of radio or television or for slide, movie (or internet) presentations, for the purposes that may include medical research or education.

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Observer's Signature or Parent/Guardian of Observer (please print)

______________________________________ ____________________

Observer's Signature or Parent/Guardian of Observer (please sign) **Date**

(Parent/guardian signature required if student is under 18 years of age)

School Approval: (For high school students only)

This experience is part of the student's career exploration program at our school. The student will engage in this experience as an educational activity authorized by the school. At your discretion, we request that you accommodate this student for a one-day Observer/Shadowing experience by placing the student with the appropriate physician or healthcare professional to maximize this educational opportunity.

School Representative: ____

Signature Date

How did you hear about this Program? (check only one):

☐ Advisor/Teacher/Professor ☐ Peer

☐ College Website ☐ Brochure

☐ HMC Website ☐ Specific direct mail/email

☐ Other ______________________

If you have participated in another HMC Program (i.e. volunteering, educational tour, courses, etc.), list the activity and when you participated: ______________________________

Is this Program a graduation project requirement? ☐ Yes ☐ No

Is this Program required by your school? ☐ Yes ☐ No

If yes, describe the requirement (number of hours, etc.) ______________________

Department Approval (for internal use only)

Department: ______________________ ______________________ ________ ________

Dept Contact Phone E-mail

Approved by: ____

Chair or Operations Director Title

Date Approved: ______________________

These forms will be on file at Penn State Milton S. Hershey Medical Center

and College of Medicine and must be updated yearly.

Please retain a copy for your records.