University of Colorado Hospital

UNIVERSITY OF COLORADO HEALTH

Educational Observation Program

PARTICIPANT INFORMATION SHEET

Date of Visit: _____ Hours for Visit: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: Code: _____

Home Phone: _____ Mobile Phone: _____

Email: _____

Date of Birth: Month: _____ Day: _____ Year: _____

Are you under age 18? *Yes* _____ *No* _____ *No participant may be under age 18*

Emergency Contact: (Name) _____ Phone: _____

College attending (if applicable): _____

Area of Interest:

_____

The reason(s) why you would like to Job Shadow at the University of Colorado Hospital:

_____

_____

Other job shadowing or volunteer experience: _____

Have you ever been convicted of a felony? Yes _____ No_____
Do you have any felony charges outstanding? Yes _____ No_____
If yes, please give date, charge, and current status.

I certify that all responses on this document are true to the best of my knowledge. I agree that this information may be verified by UCH Volunteer Services. I understand that any misrepresentation of information constitutes cause for separation or termination from the Education Observation program participation.

Signature: _____ Date: _____