

**Demographic Form – Student**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Student Information**

(Please Print)

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Last Name First Name MI

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E-mail address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School/Organization Degree Program

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expected Date(s) of Shadow

Please return completed forms to Janell Berry

jberry@dchosp.org



**Student/Job Shadow Healthcare**

All students/job shadows doing a rotation at Daviess Community Hospital understand that their training/observation is unpaid. The students are not considered employees of DCH and workers’ compensation is not available. Students are individually responsible for any and all care they may need due to any illness or injury arising out of, resulting from, or occurring in connection with their training/observation.

I have read the above statement on student health care and have had any questions answered. I understand its meaning and will abide by the requirements stated therein.

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Student’s/Job Shadow’s Name:

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Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date