Job Shadow/Observer Form

Please Print Clearly and Legibly

Last Name:	**First Name:**	**Middle Initial:**
Cell Phone:	**Email Address:**	
Are you at least 18 years old? ❑ Yes ❑ No **If not, please list age:**	**Emergency Contact:**	
Emergency Contact Relationship:	**Emergency Contact Phone:**	

Are you currently employed or volunteer at Froedtert Health ❑ Yes ❑ No **Are you currently affiliated with MCW** ❑ Yes ❑ No
If yes, please specify department and role:

Purpose of Visit

List activities and/or educational objectives for this observation:

If observation required for school:
School name:

Type/Name of Program (if applicable):	**Grade Level:**

Froedtert Health Facility - Please check one

❑ **Froedtert Hosp.**	❑ **Froedtert Menomonee Falls Hosp.**	❑ **Froedtert West Bend Hosp.**	❑ **Holy Family Memorial Hosp.**

❑ **Froedtert & Medical College of Wisconsin Clinic – Clinic location:**

Department or Occupation Requested for Observation [Identify a primary choice and secondary (back-up) choice]

Primary:_____ **Secondary**:_____

Number of Hours Requested: (no more than 4 hrs. unless agreed upon with Job Shadow Coordinator): _____	**If pre-arranged, who is the department or employee contact at Froedtert:**

Health Requirements (Must attach medical documentation)

MMR (Measles, Mumps, Rubella) –2 (two) doses of MMR vaccine **OR** 1 (one) dose quadrivalent measles, mumps, rubella, and varicella (MMRV) vaccine **OR** positive MMR titer

Tuberculosis Surveillance – One of the following is required ***(attach negative skin test, blood test or chest x-ray results)***:

- **Negative TB Skin Test** (dated within 12 months of observation start date)
- **Negative Quantiferon Gold Blood Test (IGRA) or T-Spot** (dated within 12 months of observation start date)
- **Chest X-Ray Negative for TB** (dated within 6 months of observation start date)

Influenza – During influenza season (approximately September through March) – **1 (**one) dose of vaccine
COVID Vaccine *(Recommended)-* Medical documentation of full COVID vaccination series including Booster if received (**Provide one of the following**: documentation from Wisconsin Immunization Registry (WIR) OR signed letter from the healthcare provider who administered the vaccine identifying the manufacturer, lot number and date of administration) ;COVID Vaccine Card

Signatures

I certify the information in this document and any attached documents are true, correct, and complete. I understand and agree that any misrepresentation, misstatement, or omission from this application may lead to termination of my participation in the Job Shadow/Observer Experience. I agree to report any signs or symptoms of communicable disease, including but not limited to: fever over 100.4 degrees, vomiting, diarrhea, cough, sore throat, runny/stuffy nose, body aches, or chills. **I agree I will not come to the observation if I am sick.**

Observer (Print Name):	**Date:**
Signature of Observer:	

If under 18, parent or legal guardian (Print Name):	**Relationship:**	**Date:**
Signature of parent or legal guardian:		