Memorial Hospital of Lafayette County

Health Careers Job Shadow Program

Participation Form

Please complete after your job shadow

Today's Date:_____

1. ***Your last name:_____***
2. ***Your first name:_____***
3. ***Address_____***
4. ***Home telephone number: ( )____-_____***
5. ***Name of School_____***
6. ***Grade:_____***
7. ***Department of interest:_____***
8. ***Total number of hours spent in shadow program:_____***

How would you rate the job shadow program? (circle one)

Below expectations met my expectations exceeds my expectations

What did you like best about the experience?_____

_____

_____

What did you like least about the experience?_____

_____

_____

Name two things you learned from this experience?_____

_____

_____

Have your mentor return this form to the Community Outreach Dept.