Shadow Visit Request Form

PLEASE CHECK:
☐ High School Junior
☐ High School Senior
☐ High School Graduate
☐ College Student
☐ Other ________________________________________________________________________

First Name: ______________________________________________________ Last Name: ______________________

Address: _________________________________________________________________________

City: __________________________ State: ___________ Zip Code: ___________________________

Phone: __________________________ Email: ________________________________

WHAT PROGRAM DO YOU WISH TO SHADOW?  SHADOW VISIT DATE PREFERENCE (SEE SCHEDULE ONLINE):

☐ Nursing  1. _______________________________________________________________________
☐ Radiography  2. ___________________________________________________________________
☐ Respiratory Care  3. __________________________________________________________________

WHY DO YOU WISH TO SHADOW?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

OTHER OFFICES YOU WOULD LIKE TO VISIT BEFORE/AFTER SHADOW EXPERIENCE?
☐ Admissions
☐ Financial Aid/Scholarships
☐ Current Students
☐ Faculty
☐ Accessibility Services