Student Shadow Application

CONTACT INFORMATION
NAME ____
CURRENT ADDRESS ________________________________
____
EMAIL ___________________________ PHONE NUMBER ___________________

EMERGENCY CONTACT INFORMATION
NAME ___________________________ RELATION _________________________
PHONE NUMBER ___________________

EMPLOYMENT/ACADEMIC HISTORY
CURRENT EMPLOYER AND/OR SCHOOL _______________________________________
POSITION AND/OR YEAR IN SCHOOL ____
MAJOR/FIELD OF STUDY ____
SPECIAL TRAINING, SKILLS, HOBBIES _______________________________________
____
GROUP/ORGANIZATION MEMBERSHIP ____

VOLUNTEER HISTORY
PAST VOLUNTEER EXPERIENCE ____
____
____

WHAT EXPERIENCES DO YOU HAVE WORKING WITH CHILDREN? _______________
____
____
____

WHAT ARE YOUR CAREER GOALS AND WHAT DO YOU PLAN TO DO POST GRADUATION? _
____
____
____
____

SHADOW SCHEDULE AND PLACEMENT
PLEASE CHECK THE THEARPY YOU ARE REQUESTING TO SHADOW ___ PT ___OT __ SLP
DO YOU NEED SHADOW HOURS FOR CLASS CREDIT? _________ IF YES, HOW MANY HOURS DO YOU NEED AND WHAT CLASS IS THE CREDIT FOR? ____________________________
____
WHAT SEMESTER/YEAR ARE YOU LOOKING TO COMPLETE HOURS (eg Fall 2017)? _________