Date:____________________

RETURN

Extended Job Shadow Information Sheet

Name ________________________________ Email ____

Address ____

City ________________________________ State _____ Zip ________ Phone _______________________

School/College Attending and what year in school ____

PLACEMENT: Hospital Unit Department ____

I have made contact with the department already: Yes ____ No _____

Start date ________________________ End date __________________________ Total hours ____________________

Any physical limitations we need to accommodate? _________ Explain: ______________________________

In Case of an Emergency, Who Should We Notify?

Name_____________________________________ Phone #______________________ Relationship to you______________

Physician's Name____________________________________ Phone #____

School/University Contact:

Name_____________________________________ Dept _________________________Phone #______________________

COVID Reporting Info:

I am under the age of 50: Yes ____ No _____

WAIVER AND RELEASE OF LIABILITY

In consideration of Goshen Health System, Inc. d/b/a Goshen Health or any of its subsidiary or affiliated organizations permitting the undersigned ("Applicant") to be onsite at Goshen Health facilities in a volunteer, educational or similar capacity, the undersigned Applicant agrees that such evaluation of Applicant as a potential volunteer of Goshen Health is subject to and specifically conditioned upon the undersigned agreeing to be legally bound by the following:

Waiver and Release of Liability – Applicant hereby releases and discharges Goshen Health, together with its successors, assigns, directors, officers, employees, representatives and agents, and each of them, of and from any and all claims or liability of any type whatsoever, including, but not limited to, property damage, physical injury, mental anguish, embarrassment, defamation and invasion of privacy which Applicant may suffer arising out of, based upon, resulting from, Applicant's activities at Goshen Health, including, but not limited to any claim arising out of, based upon, resulting from, or in any way connected with the negligence, omissions or other acts of Goshen Health, its successors, assigns, directors, officers, employees, representatives and agents. The undersigned Applicant further agrees and covenants not to sue Goshen Health, its successors, subsidiaries, officers, employees, representatives or agents, for any claim arising out of, based upon, resulting from, or in any way connected with the undersigned's participation in his or her volunteer duties.

By typing my name in the next box, I agree my electronic signature is the legal equivalent of my manual/handwritten signature on this form.

_______________________________________ _______________________________________

Signature Date