Children's Hospital
New Orleans
LCMC Health

Career Shadow Application

200 Henry Clay Ave.
New Orleans, LA 70118
chnola.org

Please complete this form and return it to chvolunteers@lcmchealth.org with any additional information requested below.

Student / Individual Information

Print Name: _____ Date of Birth: _____

Address: _____

Telephone Number: _____ Email: _____

School Affiliation: _____ Current or Upcoming Grade: _____

Emergency Contact Information

Print Name: _____

Telephone Number: _____ Relationship: _____

Student's Signature	Date MM/DD/YY	Time 00:00 AM/PM
X	/ /	:

Shadowing Information

Do you have a CHNOLA sponsor? Yes_____ (if yes, provide name below) No _____

A CHNOLA sponsor is an employee of Children's Hospital, with whom you have already discussed shadowing, and they have agreed to allow you to complete a clinical shadow.

Name: CHNOLA Sponsor/ Provider You are Requesting to Shadow: _____

Department/Service You are Requesting to Shadow: _____

Number of Hours student/individual is requesting to participate in a Career Shadow: _____

Time frame when Shadow needs to be completed; Proposed Beginning and End Dates: _____

Proposed Educational Purpose: (What are your goals?/What do you hope to achieve?)

_____

_____

_____

_____

_____

Volunteer Services Only

❑ Application Approved ❑ Application Denied

Signature Volunteer Services	Date MM/DD/YY	Time 00:00 AM/PM
X	/ /	: