Medical Shadowing Registration Form For High School Students

Applicant *(to be completed by applicant)*

Name: ______________________________ Date: ______________

Present address: ______________________________

Permanent address: ______________________________

Permanent phone: ______________________ Cell phone: ______________

E-mail: ______________________________

High school: ______________________ Projected year of graduation: ________

Current year in school: ______________________ Current GPA: ________

Shadowing experience requested: ______________________________

Contact faculty: ______________________________

Phone: ______________________________ Fax: ______________

E-mail: ______________________________

Dates requested: ______________________________

Affiliate location: Willmar Main Clinic Benson Granite Falls Litchfield Marshall
New London/Spicer Redwood Falls Willmar Skylark Center Willmar Surgery Center
(Your request may not be available and may be assigned)

Preceptor/Mentor: ______________________________
(Your request may not be available and may be assigned)

Health Insurance: YES NO
(Please attach copy)

Provider name: ______________________

Immunization Record to date: YES NO

Copy of Driver's License or Passport: YES NO
(Please attach copy)

Assignment *(to be completed by ACMC Physician Recruitment and Medical Rotations, Scholarships)*

ACMC approved: ______________________ Date: ______________________

Affiliate location: Willmar Main Clinic Benson Granite Falls Litchfield Marshall
New London/Spicer Redwood Falls Willmar Skylark Center Willmar Surgery Center

Preceptor/Mentor: ______________________________

Rotation dates: ________________ Orientation date(s): ______________________

Signed confidentiality contracts: YES NO Assigned name badge: YES NO

Signed affiliation agreements (ACMC/Hospital/Educational Institution): YES NO

Please return completed form to:

Alissa Gallinger, Student Affairs & Recruitment Support
Affiliated Community Medical Centers
101 Willmar Avenue SW, Willmar, MN 56201
Phone: (320) 231-5052 | Fax: (320) 231-5067
E-mail: medrotations@acmc.com

ACMC #745