UPMC Horizon

Student Mentorship Application (Job Shadow)

To Be Completed by Student: **Please Print**

Name:_____

Address:_____

_____

E-mail:_____

Home Phone ( )_____ Cell Phone ( ) _____

Date of Birth: _____

School _____

Present Grade/Level: _____Anticipated Graduation Date: _____

At **which UPMC Horizon facility** do you wish to shadow? ( ) Greenville ( ) Shenango Valley

Department you would like to Shadow: _____

List **2 preferred dates** you are available: _____

Purpose of Mentorship: _____

Please indicate any special requirements for mentorship: _____

_____

If I am placed in UPMC Horizon's Student Mentorship Program, I agree to the following:

1. I shall abide by the UPMC Visitor Confidentiality Agreement which was provided to me at the time of application.
2. I hereby understand and accept this mentorship with UPMC Horizon as described to me by my hospital supervisor and/or my school regulations. I hereby release UPMC Horizon from any or all liability arising from or in any way connected to the mentorship.
3.

_____ _____ _____

Student Applicant Signature Print Date

To be Completed by School Coordinator:

Name: _____

Address: _____

_____

Phone: ( ) _____

School Coordinator Signature: _____

Please complete and fax forms to 724-983-7939
or
e-mail to: Murphym@upmc.edu