

# CAMPERS 2017 PROGRAM

## **CHOSEN CAREER PATH:** \_\_\_\_\_

Career Path Choices: RN, RAD Tech, MT/MLT(Laboratory), Ultrasound Tech, Respiratory Therapist, Pharmacy tech, Physical Therapist.

## APPLICATION

DEADLINE FOR SUBMISSION IS FRIDAY, MAY 5TH

Please acknowledge that you will be able to participate the entire 2 weeks. (July 3<sup>rd</sup> thru July 14<sup>th</sup>) This is a requirement to be eligible.

Name: \_\_\_\_\_ (Printed)

Name: \_\_\_\_\_ (Signature)

### CONTACT INFORMATION:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

Telephone: (Work) \_\_\_\_\_ (Other) \_\_\_\_\_

Emergency Contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone:

(Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

**EDUCATION/ACADEMIC INFORMATION:**

Name of High School: \_\_\_\_\_

Overall GPA: \_\_\_\_\_

Grade in Fall 2017:    9<sup>th</sup>    10<sup>th</sup>    11<sup>th</sup>    12<sup>th</sup>

Favorite subject: \_\_\_\_\_

Have you ever participated in the S.H.I.P. Program in the past?

Yes    No    If so, what year(s)? \_\_\_\_\_

Healthcare Career Courses completed: \_\_\_\_\_

\_\_\_\_\_

Are you a member of HOSA (Health Occupations Student Association)?

Yes                  No

**EMPLOYMENT/VOLUNTEER HISTORY (If Applicable):**

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Employer's Telephone: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

Volunteer Work: \_\_\_\_\_

From \_\_\_\_\_ to \_\_\_\_\_ Contact Name: \_\_\_\_\_



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**RECOMMENDATIONS:**

Two letters of recommendation are required. Please attach them to this application and complete the following information about the person who recommended you. *Letters may not be from relatives.*

1. Name: \_\_\_\_\_ Title: \_\_\_\_\_

2. Name: \_\_\_\_\_ Title: \_\_\_\_\_

**COMMUNITY INVOLVEMENT:**

Please list any organizations in which you have participated, and your role in each.

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What are your plans after high school?

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**CAMPERS PARENTAL CONSENT FORM:**

As the legal parent or guardian of the minor child named below, I hereby provide my consent for him/her to participate in all activities and duties of the NorthCrest Medical Center CAMPERS Program. I understand that this program provides the opportunity to job shadow and gain useful knowledge about healthcare careers as well as practical work experience. I understand that although this is a five-week program, my child may be withdrawn from this program at any time and for any reason at my or NorthCrest Medical Center's discretion. I also understand that my child must NOT perform any tasks except with the direct supervision/ instruction of qualified hospital personnel. I authorize my child to have a Substance Abuse Screening performed by qualified personnel if there is any reason to suspect this unsuitable behavior. I hereby authorize NorthCrest Medical Center and its representatives to administer any necessary immediate care to my child should he/she be injured while in the course of the CAMPERS program.

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Date: \_\_\_\_\_

(Please Print)

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Telephone: \_\_\_\_\_

This year T-shirts will be required to wear with the NorthCrest logo.

The cost will be \$10.00. We will collect the fee if you are selected as a participant.

Please select size: S M L XL 2X 3X