

 **KENT CITY HEALTH DEPARTMENT**

201-G E. ERIE STREET, KENT OHIO 44240 (330) 678-8109 FAX (330) 678-2082

REQUEST TO SHADOW A KENT CITY HEALTH DEPARTMENT EMPLOYEE

Name: _____

Address: _____
(Street) (City)

Home phone: () _____ Cell phone: () _____

School: _____

What is your area of interest?

What profession would you like to shadow?

Who would you like to shadow?

Please list three dates and times that you are available to shadow:

Date: _____ Time: _____

Date: _____ Time: _____

Date: _____ Time: _____

Signature (Student): _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(If student is under 18 years of age)

(This portion to be completed by Health Department)

Request Approved by Service Area Director

Request Denied by Service Area Director

Employee student will shadow: _____

Date/Time approved by Service Area Director: _____

Signature (Service Area Director): _____ Date: _____