KENT HEALTH DEPARTMENT

414 E. MAIN ST. P.O. BOX 5192, KENT, OHIO 44240 (330) 678-8109 FAX (330) 678-2082

REQUEST TO SHADOW A KENT 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:**___________________

"This Agency is an equal provider of services and an equal employment opportunity employer Civil Rights Act 1964 (CRA)"