



**READING HOSPITAL SCHOOL OF HEALTH SCIENCES
NURSING PROGRAM
SHADOW PROGRAM REQUEST FORM**

Please have this form completed by the appropriate persons and return it to the school, as soon as possible, (within 2 weeks).

Return the form to:

Attention: Admissions
Reading Hospital School of Health Sciences
P.O. Box 16052
Reading, Pa. 19612-6052
Or Fax to 484-628-0134

Please select your current status:

- High School Student. School? _____
- High School Graduate. School and Date? _____
- College Student. School? _____
- College Graduate. School and Date? _____
- Hospital Employee
- I have applied to the Nursing Program
- I will be applying to the Nursing Program
- Other
- I would like to meet with Admissions.

Please Print

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____ Cell: _____

Email: _____

Please answer the following question:

Why do you wish to shadow?
