



**MERCY HEALTH CENTER**

Please send to:  
Mercy Health Center  
Attn: Employment Services  
4300 W. Memorial Rd  
Oklahoma City, OK 73120  
Or fax to 405-936-5484



**Application for Shadow Program**

Name: \_\_\_\_\_  
Last First

Address: \_\_\_\_\_  
\_\_\_\_\_  
City State Zip Code

Phone: \_\_\_\_\_ Age: \_\_\_\_\_

Are you an employee of Mercy Health Center? \_\_\_\_\_

Department you would like to shadow: \_\_\_\_\_

Requested Date and Time of Observation: \_\_\_\_\_

School: \_\_\_\_\_

Career Goals: \_\_\_\_\_

Do you plan to attend or are you attending college? \_\_\_\_\_

If so, where? \_\_\_\_\_