Bothwell
Regional Health Center

660-829-6652 ● 601 E. 14th St. ● Sedalia, MO 65301 ● www.brhc.org

BRHC Medical Explorer Post 75 Application

General Information

Last Name:_____ First:_____ MI:_____

Mailing Address:_____ City:_____ State:_____ Zip Code:_____

E-mail Address:_____ Social Sec # _____ - _____ - _____

Home Phone: (_____) _____ Cell Phone: (__) _____

Date of birth: _____ Highest Grade Completed:_____

Name of High School _____ Gender _____ Male _____Female

Emergency Contact:_____ Relationship:_____ Phone:_____

How did you find out about the program?

_____ BRHC Employee _____ Friend _____ Parent _____School Contact

_____ Medical Explorer _____ _____ Other _____
(Name)

Activities Information (please attach additional pages if more space is needed)

Extracurricular Activities - Please list your school and extracurricular activities (high school years only)

_____

_____

Community Service – Please list your community service activities (high school years only)

_____

_____

Essay submission

On a separate sheet of paper, please submit two paragraphs (minimum) describing the following:

- Why I am interested in a career in healthcare and the Bothwell Medical Explorer program.

Uniform

Students are required to wear khaki or black pants to meetings and job shadowing sessions. Explorers will be provided with a Medical Explorers polo shirt, also to be work during all activities.

Please circle your preferred polo shirt size below:

Women: S M L XL XXL

Men: S M L XL XXL

Program Fees

The cost of the program is $50.00 per year. Please do not enclose payment with this application. Payment of program fees will be collected at the kick-off meeting in October.

Please indicate if you participate in the free lunch program at your school and would like information about financial assistance for Explorer fees through the Zach Parsons Scholarship program? ___ yes ___ no

Terms and Conditions

I _____ have provided the information contained in this application of my own free will and certify that all statements and representations are true and correct. By signing this application, I give permission to Bothwell Regional Health Center and it's designees to use this information for its intended purpose, and hold harmless Bothwell Regional Health Center from any liability for supplying this information.

I understand that if I am accepted as a Medical Explorer, I will abide by the personnel policies and procedures put forth by Bothwell Regional Health Center, including, but not limited to attending educational meetings and aligning to the BRHC standards of conduct including adherence to patient confidentiality. I agree to provide a copy of my Driver's License or Missouri Identification Card and a copy of my most recent (current) grade card showing at least a B average. I will update these forms as my personal information changes.

I will do my best at all times to uphold the mission and quality care expectations of Bothwell Regional Health Center; and strive to maintain an enthusiastic, cheerful presentation of myself and those around me.

I, the undersigned, hereby agree to the terms and conditions of the Bothwell Medical Explorer Program at Bothwell Regional Health Center, Post 75.

►Applicant's Signature: _____ Date:_____

If applicant is under the age of 18, please have parent/legal guardian sign below:

►Parent/Legal Guardian Signature: _____ Date:_____

Please enclose:

- Application
- Essay submission
- Grade Card
- Letter of Recommendation
- Permission to Quote/Photograph/Videotape/Use For Marketing
- Release of Liability

Bothwell™
Regional Health Center

Permission to Quote/Photograph/Videotape/Use For Marketing

I, the undersigned, hereby assign to Bothwell Regional Health Center, its subsidiaries, agencies and licensees, the right and authority to use for advertising, publicity, public relations, training, trade, or other purposes the release of my name, reproductions of my image and/or voice through the media of photographic prints, video, audio recording, radio, television, Internet or through other media, and consent to the use of my name in connection therewith. I hereby represent that I am of full age, have the right to grant this authority, and waive any right to compensation for this use.

Signature _____

Name (Please Print) _____

Home Address_____

Date _____

Parent Signature _____
(if age of child is 17 or younger)

Designated Use _____

Effective date: *This agreement for use remains in effective for a period of 50 years or until one party revokes the permission by submitting the revocation in writing to Marketing Director, Bothwell Regional Health Center, 601 East 14th Street, Sedalia, MO 65301*

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Release of Liability - Job Shadowing and Medical Explorers Activities

I, _____ (print name) understand the risk and benefits of job shadowing and understand that I may be exposed to patients with a variety of health issues during observation periods. Bothwell Regional Health Center will make available safety equipment and instruction for use but it is my responsibility to follow the recommendations provided. Likewise, I release Bothwell Regional Health Center from liability or responsibility for injury or exposure sustained as a result of observing and shadowing in various locations within the organization.
In the event that I suspect I have any contagious infectious disease or symptoms, I will refrain from job shadowing and/or contact with any patient care areas.

I understand that I must produce a copy of my immunization records, in order to participate in job shadowing or volunteer in the Medical Explorers program. I acknowledge that I will be required to undergo Tuberculin Skin testing to participate in job shadowing or volunteer in the Explorer program. I also understand that I will be required to obtain a flu vaccination in order job shadow or volunteer in the Medical Explorer program. If I do not wish to obtain a flu vaccination, I will be required to wear a mask/protective equipment during all job shadowing or volunteering activities within the medical center.

I agree to the above statements, per my signature below:

_____ _____
Medical Explorer/Job Shadow Signature Date

If applicant is under the age of 18, please provide parent/guardian signature below:

_____ _____
Parent/Guardian Signature Date