West Suffolk Hospital
Student Programme Application
Clinical Shadowing Experience

Strictly Confidential

NHS
West Suffolk
NHS Foundation Trust

Voluntary Services
Tel: 01284 713209/713169
email: voluntary.services@wsh.nhs.uk

Your Details

Title ……

Forenames ……..

Surname ……..

Date of birth …… Age …….

Address
……

……..

……..

Postcode ……

Telephone Number ……

Email ……..
Emergency contact (Name and telephone number)

……..

Your School/College/Uni Details

School/College/University……..
……

……Year……...

Dates of availability/non availability:

……

Please enclose your CV and a supporting statement from your year/school head with your application.

Due to the popularity and high volume of applications that we receive, **we cannot guarantee a place for all applications**, your place is not confirmed until you have been offered a space and have completed all of the paperwork sent to you.

Please indicate your area of interest:

☐ AHP - Allied Healthcare Professions
☐ Medical
☐ Nursing

☐ Other ……

To ensure that we place you in the right environment, please explain on a separate piece of paper why you have an interest in this area. It will be useful to explain any research you have undertaken and your understanding of the roles in these professions

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Strictly Confidential—Part 2

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Health information

All students are asked to complete the Trust's Health Questionnaire which may or may not result in being asked to provide more information to the Occupational Health Department.

Disability information

Do you consider yourself to have a disability ……

If yes, what support or adjustments do you think you will need to take up a work experience placement at this Trust?

……..

Under 18 years
Please ask your parent/guardian and year Head /Tutor to complete this section.

Parent/Guardian

Name: ……

Signed ……. Date ……..

Year head/Tutor

Name: ……

Signed ……. Date ……..

Please sign below

In compliance with the Data Protection Act 1998, I declare that the information given on this form is correct and I agree to my details being held by West Suffolk Hospital Voluntary Services.

Name: ……

Signed ……. Date ……..

NB: Individual Risk Assessments are undertaken for students under 18 years.

Please complete and return to:

Rachel Grimwood
Student and young volunteer coordinator
Voluntary Services
West Suffolk Hospital, Hardwick Lane, Bury St Edmunds IP33 2QZ
email: voluntary.services@wsh.nhs.uk