West Suffolk Hospital
Student Programme Application
Clinical Shadowing Experience

Strictly Confidential

NHS
West Suffolk
NHS Foundation Trust

Voluntary Services
Tel: 01284 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 reference from your clinical dean with your application. Please see introduction email for the details.

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 Health 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

Once we have received your application you will be sent a link to our Occupational Health portal to complete our pre placement questionnaire. This may or may not result in being asked to provide more information to the Occupational Health Department.. The link for this will last 5 days, please ensure you complete as soon as possible

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 elective 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 ……

Please 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:

Voluntary Services
West Suffolk Hospital, Hardwick Lane, Bury St Edmunds IP33 2QZ
email: voluntary.services@wsh.nhs.uk