up next
A PROGRAM OF SAINT MARY'S FOUNDATION

TRINITY HEALTH GRAND RAPIDS UP NEXT APPLICATION 2026

Name: _____
First Last Middle Initial

Address: _____
Street City State Zip

Phone: _____ Email: _____

Date of Birth: _____

Company: _____ Position: _____

In case of an emergency, contact: Name _____ Phone _____

Race/ Ethnic Origin *(optional):* ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic/Latino ☐ Other: _____

I have reviewed the dates and am available to attend all the scheduled *up next* sessions _____
(February 17th, March 17th, April 21st, May 19th, and June 16th) *(Initial & date)*

- Are you involved in serving on any committees or boards within other organizations? If so, please list:

_____

_____

_____

- Is there a particular area of Trinity Health Grand Rapids which you want to learn more about?

_____

_____

PHYSICIAN SHADOW AGREEMENT

1. The above-mentioned is in good health, and immunizations and boosters are up to date.* _____ *(Initial & date)*
   **It is policy of Trinity Health that up next participants must be up to date with the following immunizations and boosters:*
   - ✓ *Influenza vaccination, and any subsequent booster vaccinations, unless Trinity Health approves an exemption for either medical contraindication or as a religious accommodation.*
2. There are no known, suspected, or alleged exposures to communicable diseases in the last 30 calendar days.
3. I agree to abide by the Trinity Health Grand Rapids policies and procedures and to fully cooperate in any arising investigation(s) should such become necessary. I further agree to respect the privacy of Trinity Health Grand Rapids patients and families and maintain patient, employee, and business-related confidentiality.
4. Visitors must be punctual, have a cooperative attitude, be properly groomed and dressed, and maintain flexibility to learn.
5. I accept all risks and liabilities associated with the physician shadow.
6. I am voluntarily entering into this agreement. I understand that I may choose not to sign this agreement. I understand that it is Trinity Health Grand Rapids' intent to protect itself from claims, suits, and liability arising out of this voluntary request. My signature waives any real, assumed, or imagined rights that I may have.
7. I understand Trinity Health Grand Rapids' right to deny any visitation request in a non-discriminatory manner. Refusal to sign this request/agreement grants Trinity Health the right to refuse access. Trinity Health Grand Rapids may deny this request for other reasons related to business necessity.
8. I understand that Trinity Health Grand Rapids is an equal opportunity employer and service provider.

We, the undersigned, agree to the terms and conditions of this agreement:
All parties will conform to all federal, state, and local laws and regulations, including non-discrimination against any individual because of race, color, age, sex, religion, marital status, national origin, ancestry, or handicap.

_____
up next Participant Signature Date