

## **Memorial Health System Summer Shadow Cohort Application**

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Birthdate: \_\_\_\_\_

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

Grade you will enter in fall 2026: 10      11      12

Preferred cohort dates: June 8 – June 19      July 6 – July 17      either

What are your future goals? \_\_\_\_\_

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Why are you interested in Memorial's Summer Shadow Cohort?

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Please send application, immunization records, transcript/report card, and letter of recommendation to [studentaccess@mhg.com](mailto:studentaccess@mhg.com). Receipt of documents will be confirmed by email.