ELIZABETHTOWN AREA SCHOOL DISTRICT
CAREER SHADOW MENTOR VERIFICATION

Student Name_____

Name_____
Occupation_____

Company_____
Phone_____

Address_____
E-mail_____

Thank you for participating in Career Shadowing. Please complete this brief evaluation of your experience today so that we can continue to improve the program. **This form will be the verification that the student completed the assignment and should be returned within two weeks of the career shadow**.

1. Arrived on time. Yes No
2. Personal appearance was appropriate. Yes No
3. Displayed a positive attitude and showed a keen interest in learning. Yes No
4. Made efficient use of his/her time. Yes No
5. Followed instructions well. Yes No
6. Displayed respect for and courtesy toward host while shadowing. Yes No

7. How would you rate your mentor Career Shadowing experience?

Very Successful	Successful	Neither	Unsuccessful	Very Unsuccessful

Comments_____
_____

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_____

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8. Can the district include your company in the Pathways Directory on the district website (www.etownschools.org) for possible career shadows in the future?

9. Any additional comments?

Career Shadow Mentor
Signature_____Date_____

Return to student or mail/fax/scan to the following address:

Elizabethtown Area High School
Pathways Coordinator
600 East High Street
Elizabethtown, PA 17022
Phone: (717) 367-1533 Ext 21106 Fax : (717) 367-2135

Phone: (717) 367-1533 X 1102