Shadowing Information

Student’s Last Name: ____________________________________________

Student’s First Name: ____________________________________________

Circle Appropriate Year: Freshman Sophomore Junior Senior
(To shadow in the Operating Room, you must be a Junior or Senior)

Student’s Phone Number(s): _______________________________________

Student’s Email Address: _________________________________________

Semester/Year Shadowing: _________________________________________

______________________________________________________________

TO BE COMPLETED ONCE PHYSICIAN IS SELECTED

Name of physician to be shadowed: __________________________________________

Email for physician (or Admin Asst): _______________________________________

Which Hospital (Adult, Children’s, VA, etc.): ________________________________

Shadowing Surgeon/OR (Yes or No): _______________________________________