SHENANDOAH UNIVERSITY
Pre-Health Programming

Pre-Health Program
Clinical Observation & Shadowing Form

Student Full Name:

Address:

City, State, Zip:

Email address and phone number:

Completed by the Student Observer

Identify your student status at the time of observation experience:

Non-Shenandoah Student: ❍ High school student ❍ College student

Shenandoah Student: ❍ Freshman ❍ Sophomore ❍ Junior ❍ Senior

Profession observed:

Name of the practice:

Address of the practice:

Name and credentials of the professional observed:

Phone number and email of the professional observed:

Brief description of practice (include setting, size of practice, type of practice, etc…):

Dates, times, and hours of observation:

Completed by the Professional

The above applicant completed hours of observation under my supervision.
Comments (optional):

I verify that the above information is accurate and I acknowledge that by signing this form, I may be further contacted in regards to this observational experience.

Name and Title: _____

Signature: _____ Date: _____