# JOB SHADOW FORM

**(TO BE COMPLETED PRIOR TO JOB SHADOW VISIT)**

Date: _____

Name: _____

Email: _____

Rank: _____

**Please answer questions below:**

1. In which hospital/clinic are you planning to job shadow?

   _____

2. What physician are you planning to job shadow?_____

3. What is his/her specialty?

   _____

4. What are the dates you plan to job shadow?

   _____

5. Who confirmed (from the physician's office) this job shadowing experience? Did you speak to physician directly or did someone else confirm this shadowing experience for you?

   _____

**Disclaimer:**

I, _____, am notifying WCUCOM that I will be job shadowing the above named physician. I understand am not allowed to, in anyway, indicate that this shadowing experience is being done as part of the WCUCUOM required curriculum. I understand this form does not give me permission to job shadow, and I further agree not to claim I am shadowing as part of the WCUCOM program. I understand I will not have malpractice coverage from WCUCOM while I am job shadowing. I agree to hold harmless and indemnify WCUCOM from any damages caused by injury or otherwise during this shadowing experience.

_____
Student Signature

_____
Approved

_____
Date Approved