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 WCUCOM 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