

*Aultman College of Nursing and Health Sciences*

*Radiography Program*

*Job Shadow Application*

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|---|
| <b>Applicant's Name:</b>  |
| <b>Address:</b>   |
| <b>Proposed Start Date for Aultman College Radiography Program: Fall 20_____</b>  |
| <b>Are you currently an Aultman College student? Yes <input type="checkbox"/> No <input type="checkbox"/> Student ID#</b> |
| <b>If no, name of college currently attending:</b>  |
| <b>Are you currently employed by Aultman Hospital? Yes <input type="checkbox"/> No <input type="checkbox"/></b>           |
| <b>If yes, which Aultman Hospital location:</b>   |

This area is to be completed by an ARRT Technologist.

|  |                                       |                                     |  |
|--|---------------------------------------|-------------------------------------|--|
| <b>Job Shadow Date:</b>                                    | <b>Start time:</b>                    | <b>End time:</b>                    |  |
| <b>Job Shadow Location:</b>                                |                                       |                                     |  |
| <b>Technologist's Name:</b>                                |                                       |                                     |  |
| <b>Observed Examinations (Please check all that apply)</b> |                                       |                                     |  |
| <b>Trauma</b> <input type="checkbox"/>                     | <b>Chest</b> <input type="checkbox"/> | <b>UGI</b> <input type="checkbox"/> | <b>BE</b> <input type="checkbox"/>             |
| <b>Pediatric</b> <input type="checkbox"/>                  | <b>IVP</b> <input type="checkbox"/>   | <b>SBS</b> <input type="checkbox"/> | <b>Other (CR, DR)</b> <input type="checkbox"/> |

**Technologist Signature:** \_\_\_\_\_ **ARRT Certificate#:** \_\_\_\_\_

This area is to be completed by the student.

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| <b>Do you feel the clinical observation was/was not beneficial in determining your decision for a career in the Radiography field?</b> |
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|  |
| <b>What did you like/dislike about your clinical observation?</b>  |
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| <b>Additional Comments:</b>  |
|  |
|  |

**Signature of Applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_