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ST. CLOUD HOSPITAL SCHOOL OF DIAGNOSTIC IMAGING

# Job Shadowing and Health Care Experience Form



**Name Date**

**Job Shadow Experience:** List your job shadowing experiences. Be very specific about the amount of time spent at each facility and what you experienced while there.

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| --- | --- | --- |
| ***Facility Name***  ***And Contact Information*** | ***Number of Hours*** | ***Radiography Related Experiences While at Facility*** |
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**Health Care Experiences:** List the Health Care Experiences(s) you have had below. Be specific about the position held, type of activity performed and length of time position in the position.

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| --- | --- | --- | --- |
| ***Facility Name***  ***And Contact Information*** | ***Length of Time*** | ***Position Held*** | ***Patient Care Related Activities Performed*** |
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