

# Shadowing Form

ARKANSAS STATE UNIVERSITY  
COLLEGE OF NURSING AND HEALTH PROFESSIONS  
Radiologic Sciences Program Shadowing Form - Confidential

Name\_\_\_\_\_ A-State Student ID  
Number\_\_\_\_\_

This student completed a shadowing experience in the Radiology Department at  
\_\_\_\_\_ on \_\_\_\_\_.  
(Date) (Facility Name)

Please provide a rating (with poor = 0 and excellent = 5) based on your perception of this student’s success in the field of medical imaging and radiation sciences. The rating should encompass interpersonal skills, dependability (i.e. was the student on time and in the correct location), as well as engagement and interest during the shadowing experience.

0    1    2    3    4    5

Why did you provide the above score?

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Please fax Shadowing Form to (870) 972-3485 or email to [mirs@astate.edu](mailto:mirs@astate.edu).

|                                          |                           |
|------------------------------------------|---------------------------|
| _____<br>Technologist Signature/Position | _____<br>Date             |
| _____<br>Email Address                   | _____<br>Telephone Number |