Department of Surgery Shadow/Observer Form

☐ BU Medical Student ☐ Other

If BU Medical Student:

Observer Attestation: I attest that I have registered for shadowing on my Student Affairs Office's Shadowing Registration Form
https://www.bumc.bu.edu/camed/student-affairs/career-planning/guided-exploration/shadowing/

_____ _____
Signature of Observer Date

Observer Name:_____
(Legal Last Name) (Legal First Name)

Home Address:_____

Telephone: (Domestic)_____ (International)_____

Date of Birth (mm/dd/yyyy): _____ Email Address:_____

Company/Education Institution: _____

Observer Attestation: I understand BMC shall not be required to provide verification that I observed.

_____ _____
Signature of Observer Date

Sponsor Information:

Sponsor's Department: _____

Dates of observation: From _____ To _____

Purpose of Observation:

_____

_____

_____

Sponsor Attestation: The observer named above will act only in the role of an observer. BMC shall not be required to provide verification. I have read the policy on observers and agree to abide by its requirements. I have also enclosed the paperwork required by the policy. I have verified the identity of the observer against a government or state issued picture ID.

_____ _____ _____
Printed name of Sponsor Signature Date

Inpatient: _____ _____ _____
Name of Patient Care Area Mgr. Signature Date

Outpatient: _____ _____ _____
Name of Administrative Dir. Signature Date