



RADIATION THERAPY PROGRAM COMPLETED OBSERVATION FORM

FORM TO BE FILL OUT BY PROSPECTIVE STUDENT AND SUBMITTED WITH PROGRAM APPLICATION

Name of Applicant: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

The applicant above has completed observation time at the named facility(s) listed below:

Name and Address of Facility: (Please print)

1. _____ Clock Hours: _____ Dates: _____

Supervisor: _____
Telephone Number: _____

Name and Address of Facility: (Please print)

2. _____ Clock Hours: _____ Dates: _____

Supervisor: _____
Telephone Number: _____

Name and Address of Facility: (Please print)

3. _____ Clock Hours: _____ Dates: _____

Supervisor: _____
Telephone Number: _____

Name and Address of Facility: (Please print)

4. _____ Clock Hours: _____ Dates: _____

Supervisor: _____
Telephone Number: _____

Name and Address of Facility: (Please print)

5. _____ Clock Hours: _____ Dates: _____

Supervisor: _____
Telephone Number: _____

I authorize the above named facility(s) to release any information regarding my observation experience to the OHSU Radiation Therapy Program. I understand that submitting any false information to OHSU will make my application for admission subject to denial, or will result in expulsion from the program. I also understand that all documents submitted to the OHSU Radiation Therapy Program become the property of OHSU and will not be returned to me.

Applicant signature: _____ Date: _____
(Required)