## CHATTANOOGA STATE COMMUNITY COLLEGE

## **Clinical Observation Form for Nuclear Medicine A.A.S.**

| Applicant Name:  |  |   |   | <del></del>   |
|--|--|---|---|---|
| Currently enrolled in  | n Radiologic Technology:   |   |   |   |
| Registered radiogra  | oher—RT Program/Gradu  | uation Date:  |   |   |
|  |  |   |   |   |
| Other  |  |   |   |   |
|  |  |   |   |   |
| minimum of 24 hours ob<br>the minimum requireme<br>within a department. Th<br>copies if needed to docu<br>Observation Evaluation I<br>Nuclear Medicine Depar | n process for the Nuclear Noservation in a Nuclear Nent of observation hours. e applicant should document more hours. Pleas Form must also be compettment: | ledicine Department. Ap<br>Applicants are individua<br>ment time spent in Nucle<br>e return this completed<br>leted and returned. | oplicants are encouraged<br>ally responsible for sched<br>ear Medicine using the c<br>form(s) with the applican | to obtain more than<br>duling observation time<br>hart below, and make<br>tion. Additionally, the |
| Date   | In Time Time Out   | Total Time  | Total Time  | Comments  |
|  |  |   |   |   |
|  |  |   |   |   |
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|  |  |   |   |   |
|  |  |   |   |   |
| Applicant Signature: Date:   |  |   |   |   |
| <b>Observation Time</b> By signing this, I verify the to complete an evaluation  | nat the above mentioned  | I student completed the   | observation time as doc   | umented. I also agree   |
| Nuclear Medicine Techn   | ologist Name (please pri   | nt):  |   |   |
| Nuclear Medicine Techn   | ologist Signature:   |   | Date:   |   |
| Facility Name: Contact Number:   |  |   |   |   |