

NUCLEAR MEDICINE TECHNOLOGY OBSERVATION FORM

THIS IS TO CERTIFY THAT _____

SS# _____

HAS COMPLETED _____ HOURS OF OBSERVATION AT

_____ ON _____
(HOSPITAL) (DATE/DATES)

CHIEF TECHNOLOGIST OR SUPERVISOR

INSTRUCTIONS

The student should:

1. Contact the Nuclear Medicine Department of the hospital in which you wish to perform your observation.
2. Set up a time with the Chief Technologist/Supervisor for your observation.
3. Complete the top portion of this form.
4. Have the Chief Technologist/Supervisor sign the form.

This form must be completed and returned by February 15, 2006 to:

**Office of Admissions
200 Oswald Building, 470 Cooper Drive
Lexington, KY 40506-0235**

RADIOGRAPHY OBSERVATION/WORK EXPERIENCE FORM

Please inform the clinical instructor or supervising technologist if there is any chance that you could be pregnant.

1. Applicant name _____ SS# _____

2. Areas applicant may observe: (Please check all applicable categories).

_____ Basic routine radiography	_____ Fluoroscopy
_____ Reception area	_____ Film storage area
_____ Emergency room	

3. Amount of time devoted: _____

Date(s) under supervision: _____

Radiography Observation/Work Experience waived by: _____

4. Any additional comments you wish to make about the applicant: _____

Signature of person supervising observation/work experience

Signature of applicant to the program

Date

Date

This form must be completed and returned by February 15, 2006 to:

**Office of Admissions
200 Oswald Building,
470 Cooper Drive
Lexington, KY 40506-0235**

RESPIRATORY CARE OBSERVATION/WORK EXPERIENCE FORM

Applicants are encouraged to complete the observation/work experience requirement with our clinical faculty. However, the observation may be completed in any respiratory care department. To arrange an observation experience with program faculty, please call the program coordinator at (859) 257-4872, ext. 4106 or a program faculty member at (859) 257-4872, ext. 4107.

To ensure the candidate has an adequate exposure to the field of respiratory care, it is recommended that an observation experience last a minimum of four hours and include at least five of the procedures listed below.

1. Applicant name _____ SS# _____
2. Salaried Employee _____ Unsalariated Employee _____ Observation _____
3. Type of experience that pertains to the applicant (please check all applicable categories):
____ Mechanical Ventilation _____ Delivery of Aerosolized Medications
____ Bronchial Hygiene Therapy _____ Oxygen Administration
____ Arterial Blood Gases _____ Pulmonary Function Testing
4. Date(s) of observation: _____
5. Approximate number of hours spent observing: _____

Signature of person supervising observation/work

Signature of applicant

Date

Date

This form must be completed and returned by February 15, 2006 to:

**BCTC Office of Admissions
200 Oswald Building, 470 Cooper Drive
Lexington, Kentucky 40506-0235.**