Delgado
COMMUNITY COLLEGE

ALLIED HEALTH ADMISSIONS

RADIOLOGIC TECHNOLOGY OBSERVATION FORM

PART I: To be completed by applicant

Applicant's Name: _____

LOLA Number: _____

PART II: To be completed by supervising Radiologic Technologist/Radiographer

Name of Facility: _____

Department: _____

Position held by applicant (if applicable):
_____

Brief description of applicant duties:
_____

Dates spent at this facility:

From: ____/____/_____ To: ____/____/_____

TOTAL HOURS: _____
Circle One:

PAID EMPLOYEE VOLUNTEER EXPERIENCE

Signature of professional verifying experience: _____
PRINT LEGIBLY

_____
SIGNATURE

_____
JOB TITLE

_____
PHONE NUMBER FOR VERIFICATION
