



**DIAGNOSTIC MEDICAL SONOGRAPHY PROGRAM  
DOCUMENTATION OF OBSERVATION FORM**

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**PART 1: TO BE COMPLETED BY THE APPLICANT**

To the applicant: Upon completion of observation, present this form with a self-addressed stamped envelope to the Sonographer who will be providing your documentation of experience.

Mail to: Delgado Community College Allied Health Admission / Sonography, 615 City Park Avenue, New Orleans, LA 70119 OR the applicant may hand deliver the signed/sealed envelope to the Allied Health Admission's Office.

Name: \_\_\_\_\_ Dates of Observation: \_\_\_\_\_

Facility: \_\_\_\_\_ Supervising Sonographer: \_\_\_\_\_

Facility / Sonographer Contact Information: Phone #: \_\_\_\_\_

Supervising Sonographer Email: \_\_\_\_\_

Volunteer Hours: \_\_\_\_ YES \_\_\_\_ NO

Paid Hours: \_\_\_\_ YES \_\_\_\_ NO

Total of Number of Days Spent Observing: \_\_\_\_\_ Total Hours: \_\_\_\_\_

Type of Facility: Hospital \_\_\_\_\_ Clinic \_\_\_\_\_ Doctors Office \_\_\_\_\_

Please check scans or procedures observed:

\_\_\_\_\_ OB \_\_\_\_\_ GYN \_\_\_\_\_ ABDOMEN

\_\_\_\_\_ VASCULAR \_\_\_\_\_ BIOPSY \_\_\_\_\_ SMALL PARTS

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

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**PART 2: TO BE COMPLETED BY THE SUPERVISING SONOGRAPHER**

Please answer the following questions concerning this applicant to the best of your ability. Your comments will be greatly appreciated.

Do you feel that you know the applicant well enough to give a reasonable, comprehensive estimate of personal character and academic ability?

\_\_\_\_\_ YES \_\_\_\_\_ PROBABLY \_\_\_\_\_ NOT SURE

Did the volunteer have any patient contact?

\_\_\_\_\_ YES \_\_\_\_\_ NO

Was the volunteer present in the procedure room during any patient examinations?

\_\_\_\_\_ YES \_\_\_\_\_ NO



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	Excellent	Above Average	Average	Below Average	Lacking Information
Initiative					
Attitude					
Attentiveness					
Interest					
Self-Confidence					
Maturity					
Communication Skills					
Behavior					

Applicant Strengths: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- \_\_\_\_\_ I recommend this applicant for admission without reservation.  
\_\_\_\_\_ I recommend this applicant for admission with reservation. Please Describe  
\_\_\_\_\_ I do not recommend this applicant for admission.

\_\_\_\_\_  
*Signature*                                      *Position/Title*                                      *Facility*                                      *Date*

\_\_\_\_\_  
Printed Name

**Sonographer: PLEASE SEAL the envelope provided by the applicant and SIGN ACROSS THE SEAL to insure confidentiality. This form may either be mailed, or hand delivered to the applicant. The student must submit the UNOPENED envelope to the Allied Health Admission’s Office. For observation at multiple sites, a document of experience form must be submitted from each site. Copies of this form are acceptable.**