



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
