



## RADIATION THERAPY PROGRAM COMPLETED OBSERVATION FORM

FORM TO BE FILL OUT BY PROSPECTIVE STUDENT AND SUBMITTED WITH PROGRAM APPLICATION

**Name of Applicant:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

The applicant above has completed observation time at the named facility(s) listed below:

**Name and Address of Facility:** (Please print)

1. \_\_\_\_\_ **Clock Hours:** \_\_\_\_\_ **Dates:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Supervisor:** \_\_\_\_\_  
**Telephone Number:** \_\_\_\_\_

**Name and Address of Facility:** (Please print)

2. \_\_\_\_\_ **Clock Hours:** \_\_\_\_\_ **Dates:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Supervisor:** \_\_\_\_\_  
**Telephone Number:** \_\_\_\_\_

**Name and Address of Facility:** (Please print)

3. \_\_\_\_\_ **Clock Hours:** \_\_\_\_\_ **Dates:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Supervisor:** \_\_\_\_\_  
**Telephone Number:** \_\_\_\_\_

**Name and Address of Facility:** (Please print)

4. \_\_\_\_\_ **Clock Hours:** \_\_\_\_\_ **Dates:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Supervisor:** \_\_\_\_\_  
**Telephone Number:** \_\_\_\_\_

**Name and Address of Facility:** (Please print)

5. \_\_\_\_\_ **Clock Hours:** \_\_\_\_\_ **Dates:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Supervisor:** \_\_\_\_\_  
**Telephone Number:** \_\_\_\_\_

I authorize the above named facility(s) to release any information regarding my observation experience to the OHSU Radiation Therapy Program. I understand that submitting any false information to OHSU will make my application for admission subject to denial, or will result in expulsion from the program. I also understand that all documents submitted to the OHSU Radiation Therapy Program become the property of OHSU and will not be returned to me.

**Applicant signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Required)