

## Clark College MRAD APPLICANT HOSPITAL/Clinic VISITATION FORM

MRAD Applicant's Name: \_\_\_\_\_

*I understand that all patient observations and information regarding anything I see, hear, or witness are strictly confidential. I have reviewed the HIPAA policies and dress code in effect at this site and realize that I am volunteering and cannot hold Clark College liable. Further, I understand there may be risks involved and I agree to assume these as part of my volunteer hours.*

\_\_\_\_\_ *Date:* \_\_\_\_\_  
*Signature of Prospective Applicant*

Name of Hospital/Clinic: \_\_\_\_\_

Where these hours obtained: \_\_\_\_\_

Date	Location	Exam	Hours	Supervised by

TOTAL Number of Hours (minimum = 40 hours) \_\_\_\_\_

What exams did you observe and what are your observations/  
comments?

Contact person at this site to be used as your reference

Name and Credentials: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Radiographer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Hours/visitation/volunteering must BE COMPLETED by the time you have been admitted to the MRAD program for enrollment consideration. Send to: MRAD at Clark College: TBG 121 Km 6/08