Health Care Provider Form on Student Shadowing Participation

Name of Health Care Provider/Supervisor:

______________________________________________________________________________

Title of Health Care Provider/Supervisor:

______________________________________________________________________________

Institution/Department/Site:

______________________________________________________________________________

Student Name: _________________________________ UM ID# ________________

Dates of Participation

<table>
<thead>
<tr>
<th>Start Date</th>
<th>End Date</th>
<th>Hours per Week</th>
<th>Total Hours</th>
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Description of student’s shadowing role:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Signature of Health Care Provider/Supervisor   Date

________________________________________________   ________________

Return Completed Form to: Office of Pre-Health Advising and Mentoring  
Ungar Building, Suite 103  
prehealth@miami.edu

For Office Use

____________  Date Received