

DIVISION OF RADIOLOGIC SCIENCES AND THERAPY

The Ohio State University School of Allied Medical Professions, 453 West 10th Ave. – Columbus, OH 43210 – www.amp.osu.edu/rd/

DOCUMENTATION OF APPLICANT’S RADIOLOGY PATIENT CONTACT HOURS

At least **50** documented radiology observation hours are REQUIRED for ALL applicants for junior-level admission consideration (by January 31).

Directions for the Applicant

1. This 2-page form must be taken to the site where you are doing your clinical observation experience whenever you are there. (Use one form for *each* facility in which you observe.) Pages may be copied as necessary for dates and hours of observation. Complete Page 1 and print your name at the top of Page 2.
2. The applicant must supply an e-mail address and/or phone number for themselves and the name and address of the facility at which the observation took place.
3. **Observation must occur in at least 2 areas** of the medical imaging department. A variety of experiences is encouraged.
4. Each time the applicant observes in the department, the setting, date, and hours spent observing must be documented here (DO NOT COMBINE DATES), and the technologist who worked with the applicant must sign ON ALL APPLICABLE DATES.
5. The printed name and credentials of the technologists must also be completed on page 2. (Email and phone should be provided if technologists so desire.)
6. At the conclusion of the observation experience, please give the form to the imaging department supervisor. The supervisor must review this form, sign it at the bottom of page 2, and mail it directly to the Division of Radiologic Sciences and Therapy at the address provided above, ATTN: Office Associate.
7. Please print neatly in the spaces provided.

APPLICANT’S NAME _____ I will apply for JUNIOR level admission by **1/31/08** _____

Indicate with 1, 2, 3 your program choice: Radiography _____ Radiation Therapy _____ Sonography _____ (Other) _____

E-mail address _____

Volunteer Setting/Institution:

Name _____

Street Address _____

City _____ State _____ Zip _____

Dates of Experience: From _____ to _____
MM/DD/YY MM/DD/YY

TOTAL HOURS (add subtotals from all pages if multiple forms completed): _____

List experience in each area in which you observed (at least 2 modalities):

Radiology Setting <small>(e.g. Diagnostic, Nuclear Medicine, Rad Therapy, Ultrasound, CT, ER, MRI, etc.)</small>	Each Date + Number of Observation Hrs. <small>(Please round to nearest HALF hour, “_.0” or “_.5”. Do NOT include lunch or dinner breaks.)</small>	Supervising Techs’ Original Signatures <small>(Technologists - please provide corresponding information and comments on page 2.)</small>
	Month/Day/Year: Number of Hours: ____/____/200__ ____:____	(1)
	____/____/200__ ____:____	(2)
	____/____/200__ ____:____	(3)
	____/____/200__ ____:____	(4)
	____/____/200__ ____:____	(5)
	____/____/200__ ____:____	(6)

Hours subtotal, this page: _____ . ____ Copy Page 1as needed for additional dates/hours.

SUPERVISING TECHNOLOGISTS:

Applicant's Name _____

Full name and contact information for each supervising technologist signing the chart on Page(s) 1 should be included below. Hours completed, supervisor comments, and applicant's description will all be used in the application evaluation process. [Supervisors (1) to (6) – title/credentials required; e-mail and phone information optional.]

(1) Supervising technologist (please print) _____

Title/credentials _____

E-mail _____ Phone _____

Comments _____

(2) Supervising technologist (please print) _____

Title/credentials _____

E-mail _____ Phone _____

Comments _____

(3) Supervising technologist (please print) _____

Title/credentials _____

E-mail _____ Phone _____

Comments _____

(4) Supervising technologist (please print) _____

Title/credentials _____

E-mail _____ Phone _____

Comments _____

(5) Supervising technologist (please print) _____

Title/credentials _____

E-mail _____ Phone _____

Comments _____

(6) Supervising technologist (please print) _____

Title/credentials _____

E-mail _____ Phone _____

Comments _____

Directions for the Department Supervisor

1. Please verify that the information included by the applicant, along with the staff information for your department, is both accurate and authentic.
2. This form must be signed by the Department Supervisor and then returned to the **Division of Radiologic Sciences and Therapy** at The Ohio State University at the address provided at the top of Page 1. Thank you for your time.

Department Supervisor's signature and credentials _____

Supervisor's printed name _____ Date _____

Supervisor's phone (____) _____ E-mail address _____