DEPARTMENT OF
RESPIRATORY THERAPY

Odessa College Respiratory Care Program

Observation (Shadowing) Verification Form

Student Name: ____________________________________ **Student ID (if applicable):** __________

Phone Number: ___________________________________ Email **Address:** ____________________

Facility Name: ___________________________________

Preceptor / Supervisor Information

Name: ____ **Title/Position:** _____________________

Phone Number: _________________________________ **Email Address:** _____________________

Student Attestation

I certify that I have completed the observation hours listed below in a professional manner.

Total Observation Hours Completed: ______________________

Student Signature: ____________________________ **Date:** __________________

Preceptor / Supervisor Verification

I verify that the above-named student completed the observation hours as documented.

Preceptor Signature: ___________________________ **Date:** __________________

Program Verification (Office Use Only)

Verified by: ______________________________________ **Date Received:** _____________________