UNIVERSITY of WISCONSIN
LA CROSSE
Nuclear Medicine Technology
4033 Health Science Center
La Crosse, WI 54601
FAX: 608-785-8460
Email: astaffaroni@uwlax.edu

CLINICAL OBSERVATION FORM

Student's Name:

I waive my right to inspect this document: Yes No Student's Signature: ______________________________

Nuclear Medicine Department/Site observed:

Dates & times of observation(s) (list all):

Student: Please complete the above, and then give this form to the nuclear medicine technologist who worked with you the most during your observation.

Nuclear Medicine Technologist: Please complete the form below regarding the student during his/her observation time in your department, and fax or email to Aileen Staffaroni at the above address.

	Excellent	Very Good	Average	Below Avg.	Poor
Level of interest in NMT	5	4	3	2	1
Questions asked	5	4	3	2	1
Maturity	5	4	3	2	1
Use of time	5	4	3	2	1
Communication with staff	5	4	3	2	1
Communication with patients	5	4	3	2	1
Student's aptitude for NMT	5	4	3	2	1

Technologist's comments:

Thank you for your help!

______________________________ NMT's Name

__________ Date