Physician Shadowing
MUN MedCAREERS
Faculty of Medicine

Physician Participation Form

Name (please print): _____Specialty:_____

I am interested in participating in Physician Shadowing:

YES:___ NO:___

If YES, please complete the following:

Office Location: _____

Full Mailing Address (including postal code): _____

Contact Numbers: Phone:_____ Fax: _____

E-mail: _____

Please check **ALL** available **months** and **time periods:**

___ September
___ October
___ November
___ December
___ January
___ February
___ March
___ April
___ May
___ June

___ Tuesday (2:00 – 5:00 p.m.)
___ Other available days/hours:_____

Agreement to Participate

I understand that Physician Shadowing is an opportunity for first-year and second-year medical learners to get exposure to the different specialties. Learners may spend time with physicians in clinics, the OR, the ER, ward rounds, home visits or a variety of other settings.

I agree to accept learners who are registered to shadow with me for the months and times indicated above. I will oversee and directly supervise their experience and obtain verbal consent from the patient, whenever possible.

Physician signature:_____ **Date:** _____

Witness (student or other)**:** _____

NOTE: It is the responsibility of the learner who first shadows this physician in each academic year to ensure that the physician has read and signed this participation form. When signed, all forms must be submitted to Shadowing Coordinator.