Student Shadowing Report

Please print or type

Your name: _____

Number of hours shadowed: _____

Name of health professional you shadowed: _____

Facility name: _____

1. What did you do?

2. What did you learn?

3. What did you like about the shadowing experience?

4. What did you dislike about the shadowing experience?

5. Before others participate in shadowing, they should know:

6. My preceptor gave me valuable insight into his/her profession (circle one):

POOR 1 2 3 4 5 EXCELLENT

7. Overall, I would rate my experience (circle one):

POOR 1 2 3 4 5 EXCELLENT

8. I would recommend this shadowing site/preceptor to others (circle one):

YES NO MAYBE

Additional comments, please.

Signature of Student

Date of Shadowing Experience

Please return completed form to:
East Central Missouri AHEC
3115 South Grand Suite 313
St. Louis, MO 63118

For questions, please call:
314-772-9979