



Diagnostic Medical Sonography Observation Form



INSTRUCTIONS:

- 1) This is a medical facility, please act professionally.
- 2) Please respect patient's rights and privacy at all times.
- 3) Ask questions. It's the best way to understand our profession.
- 4) Please dress appropriately for a hospital atmosphere. No jeans, sweatpants, miniskirts or open-toed shoes. Wear comfortable walking shoes.
- 5) Do not use your cell phone while observing.
- 6) Do not bring family members or friends with you to the observation experience.
- 7) All observations must be completed within 12 months of applying to the program.
- 8) **Upon completion, please scan and email completed form to DMSprogram@clarkstate.edu.**
- 9) Submit this form when submitting your application for the Diagnostic Medical Sonography Program at Clark State College.

PROSPECTIVE SONOGRAPHY STUDENT:

I, _____, have read the above instructions and agree to all conditions. My signature below indicates agreement and understanding to abide by all policies and procedures of the facility where my observation experience will take place. I understand this experience may be discontinued at the discretion of the facility or college for any reason at any time. In addition, Clark State College and the healthcare facility are released from any and all responsibility regarding any accident, incident or injury that might occur during my observation experience.

Student Signature: _____ **Date:** _____

SONOGRAPHER:

The individual named above has completed _____ hours of observation in our sonography department on this date(s): _____

Sonographer Name: _____

Sonographer Signature: _____

ARDMS #: _____

Facility Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Department Phone Number: _____

Please list the exams observed:



Clinical Ultrasound Observation Evaluation Form



FOR THE APPLICANT:

Please have this form filled out by the ARDMS registered sonographer you observed with the most during your experience. By signing this form, you are authorizing the individual permission to complete an evaluation of you. This evaluation will become part of your program application and will remain confidential.

Applicant Name (please print): _____

Applicant Signature: _____ **Date:** _____

FOR THE EVALUATOR:

Thank you for allowing this prospective applicant the opportunity to observe in your imaging department. Your input is a valuable part of our selection process. This form is intended to be turned in via email to DMSprogram@clarkstate.edu by the evaluator or the student. If you prefer to submit the form yourself, please submit to the DMS program within 48 hours of completion.

Please rate the prospective applicant in the following areas using the defined grading scale:

4 = Superior, 3 = Good, 2 = Average, 1 = Poor, 0 = unacceptable

CHARACTERISTIC:	4	3	2	1	0
Ability to learn: they learned rapidly and information did not need to be repeated					
Attitude: they were positive, energetic and inquisitive					
Communication: they communicated clearly and effectively					
Concern for patients: they were considerate and thoughtful of patients and their needs					
Initiative: they actively sought out details about the profession and asked questions					
Judgement: they used common sense when applicable and made educated decisions					
Motivation: they appeared enthusiastic and eager					
Professional behavior: their behavior was appropriate at all times					
Punctuality: they arrived at the designated time					
Responsibility: they appeared responsible throughout shadowing					
Self-confidence: they displayed confidence and maturity					

Additional comments:

Overall, would you recommend this prospective applicant?

Yes No

Sonographer Name (please print): _____

Sonographer Signature: _____ **Date:** _____

For additional comments and concerns about this student, please email the DMS program director, Megan Platfoot, at platfootm@clarkstate.edu.