VANDERBILT UNIVERSITY MEDICAL CENTER

CASE SHADOW FORM

PERFUSION PROGRAM

PERSONAL INFORMATION

Name of Applicant: _____

Mailing Address: _____

E-mail Address: _____ Phone Number:_____

CASE INFORMATION

Shadowing includes contacting at least one community perfusionist, requesting the opportunity to observe him or her in their practice, and spending at least four hours observing in the clinical setting. Please complete all of the following information for your shadowing experience.

Hospital Name: _____ Date of Visit: _____

Mailing Address: _____

Perfusionist Observed: _____ Signature: _____

Case(s) Observed:_____

_____

_____

_____

_____

Describe your experience:_____

_____

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