Northwest
SCHOOL OF MEDICINE

SHADOWING PROGRAM

NWSM/NWGH/NWTH

Clinical Faculty Participation Form

Name: _____

I am interested in participating in the Shadowing Program: ☐ YES ☐ NO

If YES, please complete the following:

Teaching Hospital: ☐ NWGH ☐ NWTH

Specialty: _____

E-mail: _____

Participation Agreement

I agree to accept students who have applied and are registered for shadowing at NWGH/NWTH. I will provide students, shadowing me, all relevant and available clinical exposure. I will directly supervise their clinical interaction with patients under my care and will obtain verbal consent from patients wherever applicable.

Clinical Faculty Signature: _____

Date: DD/MM/YYYY

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