University of Nebraska at Kearney
Health Sciences

Shadowing Experience Documentation

Student Name: _____

Health Profession Shadowed: _____

Location/Organization: _____

Date/Time of Experience(s): _____
_____
_____
_____
_____
_____

Total Number of Hours: _____

Name of Health Care Professional: _____
(Please Print)

Title: _____

Address: _____

Phone: _____

Signature of Professional: _____

Comments of the Health Care Professional (optional):