Pre-Clerkship Physician Shadowing Experience
(one form needed per experience)
MICHIGAN STATE UNIVERSITY COLLEGE OF OSTEOPATHIC MEDICINE

Section 1: To Be Completed by Student

Student Name/PID: ________________________________________________________________
is requesting permission to complete a Physician Shadowing Experience at ________________________________ Hospital/Clinic (circle one) on the following date(s) ________________________________ with Dr. ________________________________ serving as the Supervising Physician.

Physician/Clinic contact # ________________________ Specialty ________________________________

Student contact # ___________________________ Student e-mail address __________________________

_____________________________________________________________ ________________________
Name and Title (Printed)    Signature

Phone and Email        Date

No participation and no malpractice insurance coverage without completed form and all required signatures **10 days prior** to the first day of the shadowing experience.

Required Department Signatures:
(or Medical Office Official signature if shadow is not through a COM department)

___________________________________________ ___________________________________________
Name and Title (Printed)    Signature

Phone and Email        Date

Section 2: To Be Completed by MSUCOM

DMC and MUC students, please take the completed form to your Student Services Representative. East Lansing students, please take completed the form to the COM Office of the Registrar, East Fee Hall Room C110.

Eligibility Verification: _________ (initials)

Compliance Verification: _________ (initials)

College Official Signatory: ________________________________ Date: ________________

Revised 09/02/2015