



School of Radiation Therapy

DOCUMENTATION OF OBSERVATION HOURS AND RECOMMENDATION

Part A: To be completed by Applicant

Applicant Name: _____ Applying for program year: _____

Part B: To be completed by Chief or Supervisory Therapist:

The above individual is a prospective student applying to the City of Hope Radiation Therapy Program. He/She has requested documentation of observation hours performed at your facility and a recommendation for the program.

The purpose of this observation is for the applicant to gain a greater appreciation for the practices of radiation therapy and the profession.

After the applicant has completed their observation, please complete and sign this form and FAX it to:

Christine Forell, Program Director
City of Hope, School of Radiation Therapy
Department of Radiation Oncology
Fax number: 626-218-5334
Duarte, Ca 91010

Radiation Facility: _____ Number of observation hours completed: _____

Please rate the applicant on the following qualities:

Table with 6 columns: Quality, 4 Excellent, 3 Above Average, 2 Average, 1 Below Average, Not Observed. Rows include Professional attire, Initiative, Punctuality, Maturity, Positive Attitude, Interest Shown During Observation, Communication Skills, Ability to Work With Others, Relationship with Patients, and a final row for recommendations and comments.

Chief/Supervisory Therapist Signature/Date

