IDAHO STATE UNIVERSITY COLLEGE OF TECHNOLOGY
RESPIRATORY THERAPY
PROGRAM SHADOW

Prospective Student’s Name (please print): ___________________________ Student ID #: __________

This program shadow is a sample of what we would like prospective students to see. Not all aspects of respiratory care are listed below. Your institution may be able to show more, but we would like the prospective student to at least see what is listed at a minimum. Please initial beside each completed item. If you have any problems or questions, you may call the Respiratory Therapy Program at 208-282-3653. Thank you for your continuing help in the promotion of our field. This form should be given back to the student in a sealed envelope for return to Student Services at the ISU College of Technology, or it may be faxed to the number listed on the second page.

Student’s Signature ___________________________ Date ___________________________

Experience must have been obtained within the last ten (10) years.

__________ AARC Life and Breath Video Watched (http://www.aarc.org/careers/what-is-an-rt/life-breath-video/)

__________ Meet Department Manager or Supervisor

__________ Tour Department and Hospital

__________ Adult ICU

__________ Observe ABG

__________ Observe Suctioning

__________ See PFT Lab

__________ NICU/PICU

__________ Observe Vent Check

__________ Observe Med Neb Rx

__________ See an ETT or Trach
Any additional area(s) of observation? _____________________________________________________

Did the student show up on time? ________ If not, did she/he give a reason? ___________________

Did the student appear to have effective verbal communication skills? ___ Yes ___ No. If not please explain. ________________________________________________________________

Did the student appear to be motivated/goal directed about the field of respiratory care and the tour? ____ Yes ____ No. If not please explain. ________________________________________________________________

Any comments or concerns about the student? (This is strictly confidential and will only be seen by key program faculty.) ________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Dates student job shadowed: _____/_____/_____ To _____/_____/_____. Total hours: ___________

Therapist’s Signature ___________________________ Date ___________________________

Hospital Name ___________________________

Hospital Address ___________________________

Please complete this form and return it to the applicant in a sealed envelope, or you may send or fax it to the office listed below. (Please copy if you need more forms.)

Idaho State University
College of Technology
Student Services Office
921 South 8th Ave, Stop 8380
Pocatello, ID 83209-8380
Phone: 208-282-2622
Fax: 208-282-5195

These hours must be completed and the form received in Student Services by the application deadline of February 15, 2019.

REV 10/17/18