

**M*A*S*H
SHADOWING PREFERENCES FORM**

STUDENT NAME:

To assist in making the M*A*S*H Program most beneficial to you, please indicate below your particular areas of interest for shadowing.

Please select and rank in order your top four choices. **Rank choices 1 (first choice) to 4 (last choice).** Please feel free to write in any area of interest not listed.

	Critical Care/Intensive Care	Rehab Services/Physical Therapy/Occupational Therapy
	Dietary Services – Registered Dietician	Radiation Therapy
	Emergency Department	Surgery
	Emergency Medical Services (EMS)	Wound Care
	Home Care/Hospice	OFF CAMPUS OPPORTUNITIES
	Imaging Department	Veterinarian
	Laboratory	Chiropractor
	Nursing Floors	Dentist’s Office
	OB/Women’s Health	Doctor’s Office
	Pharmacy`	Optometrist’s Office
	House Supervisor	

OTHER:
