M*A*S*H
SHADOWING PREFERENCES FORM

STUDENT NAME:
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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:

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