CLINICAL OBSERVATION

Prospective Radiography students are required to observe the role of the radiographer in the clinical setting. THE MINIMUM OBSERVATION PERIOD FOR ADMISSION INTO THE RADIOGRAPHY PROGRAM IS 4 HOURS. This may be achieved by contacting one of the six local hospitals listed on the Clinical Observation Form. If you reside outside of the four-county IRSC service area, you may perform your observation at a hospital near your residence. In this instance, be sure to provide a written letter (on hospital letterhead) that documents your observation. Attach the letter to the Clinical Observation Form (page 20) and return it to IRSC at the address provided below. Proper attire for the observation is required.

Clinical observations may only be scheduled between 8:00 a.m. - 12:00 Noon on Monday-Friday.

Take the Clinical Observation Form with you for your observation. Upon completion of your observation, the form will be retained by the clinical site.

Whom should I contact for additional information?

If you need additional information, contact the Educational Services Division at (772) 462-4740 (St. Lucie County), or 1-866-792-4772 toll free. Or contact the Radiography Department:

Dr. Gary Shaver, Department Chairman  (772) 462-7541
Kelly Arnone, Clinical Coordinator  (772) 462-7540
Clinical Observation Form

Contact one of the clinical facilities listed below. Ask to be connected to the Radiology Department. Speak to the Lead Clinical Instructor and arrange for an observation (minimum 4 hours) in the Radiology Department. Clinical observations may only be scheduled between 8:00 a.m. - 12:00 Noon on Monday-Friday.

<table>
<thead>
<tr>
<th>Clinical Site</th>
<th>Contact*</th>
<th>Phone</th>
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</thead>
<tbody>
<tr>
<td>Indian River Medical Center</td>
<td>Brenda Baker</td>
<td>(772) 567-4311 ext. 2080</td>
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<tr>
<td>Vero Beach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lawnwood Regional Medical Center</td>
<td>Alana Robertson</td>
<td>(772) 468-4435</td>
</tr>
<tr>
<td>Fort Pierce</td>
<td></td>
<td></td>
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<tr>
<td>Raulerson Hospital, Okeechobee</td>
<td>Melissa Mills</td>
<td>(824) 284-2982</td>
</tr>
<tr>
<td>St. Lucie Medical Center</td>
<td>April Borecki</td>
<td>(772) 335-4000 ext. 172</td>
</tr>
<tr>
<td>Port St. Lucie</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Martin Memorial Medical Center</td>
<td>Diane Komara</td>
<td>(772) 288-5895</td>
</tr>
<tr>
<td>Stuart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Martin Memorial Hospital South</td>
<td>Dawn DeBartolo</td>
<td>(772) 223-5945 ext. 6839</td>
</tr>
<tr>
<td>Stuart</td>
<td></td>
<td></td>
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</tbody>
</table>

*as of June, 2011

Attire For the Observation

Men: Dark, clean shoes and trousers; light shirt and tie.

Women: Slacks with appropriate top, dress or business suit.

Note: Wear comfortable shoes (no high heels, or open-toe shoes). You will be standing most of the day. Any applicant who arrives for the observation inappropriately dressed will be sent home and asked to reschedule.

Sign the confidentiality statement on the reverse side of this form. Give it to the lead clinical instructor at the time of your observation for his/her signature, which verifies your attendance. YOU ARE RESPONSIBLE for returning this form to IRSC Radiography Department, 3209 Virginia Avenue, Fort Pierce, FL 34981.
Confidentiality Statement
The patient has a right to every consideration of privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present. The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.

A Patient’s Bill of Rights (1975)

I am aware that as an applicant to Indian River State College Radiography program, I may have access to patient information that will remain confidential. I agree to respect and protect the confidentiality of all patient information.

Printed Name of Applicant

Signature  Date

Clinical Observation Form Con’t.

Clinical Instructor Use Only

Name ___________________________  Student I.D. No. ___________________________

Hospital ___________________________

Date of observation ___________________________

Time arrived ___________________________  a.m./p.m.  Time left ___________________________  a.m./p.m.

Comments: ___________________________

Signature ___________________________  Date ___________________________

PLEASE RETURN THIS FORM TO THE APPLICANT

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