UNM COLLEGE of ARTS & SCIENCES and SCHOOL of MEDICINE

Combined BA/MD Degree Program

Shadowing Verification Form

Student Name: _____

Physician Name:_____

Location: _____

Date	**Time**
Date	**Time**
Date	**Time**
Date	**Time**
Date	**Time**

(If you need additional space, please use the backside of this form.)

Please describe what the student was able to observe/experience during their shadowing time.

Please list your contact information or attach business card.

Name	
Location	
Email	
Phone Number	

Signature: _____

Date: _____