The participant is responsible for the documentation of their shadowing hours. The Volunteer Service office does not retain records of shadowing hours.

Documentation of Shadow/Observation Time

Facility Name _____

Department _____

Shadowing/Observation Schedule

Date_____Time_____ Total Hours Shadowed: _____

Name of Therapist: _____

Email of Therapist: _____

Supervisor Signature: _____

Date_____Time_____ Total Hours Shadowed: _____

Name of Therapist: _____

Email of Therapist: _____

Supervisor Signature: _____

Date_____Time_____ Total Hours Shadowed: _____

Name of Therapist: _____

Email of Therapist: _____

Supervisor Signature: _____

Thank you for choosing Carolinas Rehabilitation for your shadow/observation experience.