



OBSERVATION REQUEST

The following information will be needed to obtain hospital approval for this request. Please submit this request along with the attached paperwork 48 hours prior to requested observation time.

Today's Date: _____

Name of Requestor: _____

Address: _____

City/State/Zip code: _____

Phone: _____

Email Address: _____

Contact Person in case of an Emergency:

Name _____ Phone _____

Relationship _____

REQUEST INFORMATION

1. Name of school or sponsoring agency: _____

Contact person at school or sponsoring agency: _____

Phone: _____

2. Current type of school: High School _____ College _____
Other (please specify) _____

3. Areas of the hospital for observation; _____

4. If you are under the age of 18 a parent or guardian signature is required below.

(Parent or Guardian- print name)

(Parent or Guardian signature)

NOTE: MAXIMUM OF 12 HOURS ALLOWED FOR OBSERVATION EXPERIENCES

- 5. Desired starting date _____ day(s) of week _____
- 6. Desired daily starting time: _____
- 7. Desired number of hours per day: _____
- 8. Desired number of days: _____

List your objectives for this experience:

How do you plan to use the knowledge gained from this experience?

Student/Observer signature

Return this form and attached paperwork to:

Education Department
Hutchinson Regional Medical Center
1701 E. 23rd Street
Hutchinson, Kansas 67502

Can be faxed to (620) 513-3813

For questions call: (620) 665-2057