HUTCHINSON
REGIONAL MEDICAL CENTER

OBSERVATION REQUEST

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

Today's Date: _____ Date of Birth:_____

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 requested 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 (print)

_____
Student/Observer (signature)

Return all forms 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