



THE UNIVERSITY OF ARIZONA  
COLLEGE OF MEDICINE TUCSON

Surgery



Banner  
University Medical Center

# Shadowing / Observership Inquiry

Name: \_\_\_\_\_

Organizational affiliation (if applicable): \_\_\_\_\_

Are you a medical student? \_\_\_\_\_

Are you under the age of 18? \_\_\_\_\_

Email: \_\_\_\_\_

Date(s) of Proposed Visit: \_\_\_\_\_

Hours/Duration of Proposed Visit: \_\_\_\_\_

Specialty/Physician you would like to observe: \_\_\_\_\_