



Shadowing / Observership Inquiry

Name: _____

Organizational affiliation (if applicable): _____

Are you a medical student? Yes No

Email: _____

1. Are you an international student or physician? Yes No

2. Are you under the age of 18? Yes No

*If checked yes to the two questions above, please review our eligibility requirements for shadowing/observing
<http://surgery.arizona.edu/education/observershipshadowing-program>

Date(s) of Proposed Visit: _____

Hours/Duration of Proposed Visit: _____

Please rank the top three specialties you would like to observe:

- | | | |
|----------------------|--------------------------------|--------------------------------------|
| Abdominal Transplant | Endocrine | Minimally Invasive/Bariatric |
| Breast | General Surgery | Pediatric General & Thoracic Surgery |
| Cardiothoracic | HPB (Hepatopancreaticobiliary) | Trauma |
| Colorectal | Melanoma/Sarcoma | Vascular |