



Physical Therapy and Occupational Therapy

EVALUATION OF JOB SHADOWING EXPERIENCE

School Name (if applicable): _____

Date(s) of Experience: _____

Department: _____

Preceptor: _____

Please place an (X) in the appropriate box below, as it relates to your experience...

Categories	Poor	Fair	Good	Very Good	Excellent
Opportunities for clinical exposure					
Quantity of experiences made available					
Overall rating of job shadowing experience provided					
Overall rating of staff's helpfulness					

How could we improve this experience in the future? _____

What did you enjoy the most? _____

Comments _____

Signature (optional) _____