UMKC School of Medicine Shadowing Form

Documentation of Shadowing Experience

Applicant name: _____Last 4 digits of SSN:_____
Last *First*

In brief paragraph, describe your shadowing experience.

Complete the information below and ask the Medical Provider who supervised your experience to sign and date the verification form.

Provider's Name_____Title_____

Facility_____

Provider's signature _____Date _____

Duration of Shadowing Experience (in hours) _____

This form should be submitted electronically via the UMKC School of Medicine Online Student Portal. Access to the Portal will become available upon the verification of your application. Please reach out to the UMKC School of Medicine Office of Admissions with any questions.