Kaleida Health

Request letter to be completed by Provider being shadowed

Shadowing Request Letter

Provider Name: _____

Provider Group/Location:

_____

_____

_____

Individual Shadowing: _____

DOB: _____

Email Address: _____

Requested shadow dates: _____

(Must list specific date range)

To whom it may concern:

Please allow the above mentioned individual to observe/shadow me on the above listed dates.

The shadowing will take place at _____.

The individual will at no time be assisting with any patients and I take full responsibility of their actions while under my supervision.

_____ (Name of individual shadowing) would like to gain more knowledge of the medical field and consider pursuing a career in Medicine.

Provider Name (Print): _____

Provider Signature: _____

If individual is shadowing more than one provider please list the first and last names of those providers below:

_____ _____

_____ _____