



Sonography Applicant Log Sheet
for the
Diagnostic Medical Sonography Program

Thank you for allowing this perspective applicant for the **Diagnostic Medical Sonography** program at **Kilgore College** to shadow at this facility. The DMS program at Kilgore College greatly appreciates your time and expertise with this student. This form must be signed by the credentialed sonographer(s) that worked directly with this student.

Thank you in advance for assisting this student.

Date (circle)	Hours	Name of Hospital/Clinic/Private Practice	Sonographer Name	Credentials
				AB OB/GYN VT BR
				AB OB/GYN VT BR
				AB OB/GYN VT BR
				AB OB/GYN VT BR
				AB OB/GYN VT BR
				AB OB/GYN VT BR
				AB OB/GYN VT BR
				AB OB/GYN VT BR
				AB OB/GYN VT BR
				AB OB/GYN VT BR

A total of **eight (8)** hours **ONLY** will be accepted. Additional hours will not benefit the applicant and or add additional points to the application packet.

At any time, feel free to contact the **DMS Program Director** at kevans@kilgore.edu as needed.



Sonography Applicant Shadow Evaluation
for the
Diagnostic Medical Sonography Program

Thank you for allowing this perspective applicant to the DMS program at Kilgore College to shadow your facility. The DMS program at Kilgore College greatly appreciate your time, expertise and professional evaluation of this student.

This form must be completed by the credentialed sonographer (s) that worked directly with this student. Then place this evaluation in a sealed envelope (provided) and return back to the student.

Thank you in advance for answering the following questions.

Please Rate: (3) Agree (2) Disagree (0) Neither Agree nor Disagree (Indifferent)

Name of Hospital, Clinic or Private Practice:	
Student (insert name here):	Rate
Arrived on time as scheduled.	
Was professional and respectful to all healthcare staff.	
Was neatly dressed according to your facilities standards.	
Showed a true interest in watching all the sonography procedures.	
Followed the facilities best practices for patient privacy and HIPAA.	

Any additional comments regarding this candidate:

Sonographer's Printed Name:	
Sonographer's Signature:	Date:
Credentials / Circle all that applies: AB OB/GYN VT RDCS BR	Total Points: KC/DMS ONLY