

**Jackson State Community College  
Respiratory Care Technology Program  
Observation Form**

In order to begin the observation process, you must follow these steps:

1. If interested in observing at JMCGH you must have internet and printer access to complete the required process for observation.
  - a. Go to <http://www.wth.org/body.cfm?id=2179> and follow the directions for job shadowing.
  - b. You must follow the directions as stated on the web site prior to scheduling the observation time.
  - c. Students are only allowed to perform eight (8) hours of observation at JMCGH.
  - d. Due to the limitation in the number of students that can perform observation at a time at JMCGH it should be scheduled prior to May if at all possible or you may not have an opportunity to observe there.
  - e. Ray Davis is the contact person in the Respiratory Care department at JMCGH. He can be reached at (731) 541-5531.
2. If you would like to observe at Regional Hospital of Jackson, please phone (731) 661-2198, and speak with Jeff Davis.
2. If interested in observing at any other hospital, call the Respiratory Care Department of that hospital to arrange for completing the observation requirement.
3. Regardless of where the observation occurs, students must wear khaki pants and a polo type shirt without logos. No perfume or cologne is permitted. Students will be sent home if not dressed appropriately.
4. The attached observation form must be completed and included when submitting the application for admission to the program. Eight (8) hours of observation are required.

# Jackson State Community College

## RESPIRATORY CARE TECHNOLOGY PROGRAM OBSERVATION/VOLUNTEER FORM

STUDENT NAME \_\_\_\_\_

As a part of the requirements for application to the Respiratory Care Technology Program, students are required to spend 8 hours of observation/volunteer time in a respiratory care department.

Respiratory Care Department \_\_\_\_\_

Total time of observation at this facility \_\_\_\_\_

Type of care observed \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Comments \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Signature of Therapist:

\_\_\_\_\_

TN Certificate # \_\_\_\_\_

Date \_\_\_\_\_