



**Diagnostic Medical Sonography Program
at University of Colorado Hospital**

**Diagnostic Medical Sonography Program at University of Colorado Hospital
Observation Form**

| Date | Hospital/Clinic | Procedure | Sonographer | Sonographer Signature and Credentials | Time (in hours) |
|------|-----------------|-----------|-------------|---|-----------------|
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Total hours of observation spent in imaging locations:

Applicant Signature: _____