Peconic Bay Medical Center
Northwell Health®

School of Radiologic Technology

DATE: _________________________

To Whom It May Concern,

This is to verify that ____ completed ______________

observation hours shadowing a Radiologic Technologist in the Diagnostic Imagining Department at

____. *(Students should complete a minimum of four hours.)*

Radiology policies and procedures were explained and observed.

Please include any additional comments below.

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Evaluator: ____ (Print)

Signature: ____