DEPARTMENT OF MEDICAL IMAGING AND RADIATION SCIENCES
PROFESSIONAL EMPLOYMENT NOTIFICATION

Please complete the following information and return to the departmental office.
Date _____

Name and major: _____

1. **Institution/site of professional employment**: (facility name and address)
   _____
   _____
   _____

   Phone number: _____ Fax number: _____

2. **Name, Title and Credentials of Supervisor(s)**:
   1. Supervisor who discussed clinical assignment and/or employment with you:

   2. If different, supervisor who you will report to in the employment situation:

3. **Condition of supervision** (by certified practitioners, physicians, etc.):

4. **Employment hours** (shifts(s), working hours, days):

5. **Projected starting date**:

6. **I acknowledge the following**:

   A. My student malpractice insurance is applicable and valid only when I am functioning as a student. When functioning as an employee my student malpractice insurance is negated. I may wish to consider supplemental malpractice insurance, or check with my employer with respect to insurance as an employee.
   B. Acknowledgement of this information in no way implies any departmental responsibility for me when engaged in activities related to employment.
   C. Extracurricular employment does not substitute for the regularly scheduled clinical education requirement in my educational program.
   D. My educational responsibilities and objectives should not be compromised by obligations as an employee. The department would not wish to see me compromise my educational goals.
   E. It is the responsibility of the Radiation Safety Office of the employing facility to provide to me a radiation safety monitor to use during my employment hours.
   F. It is understood that I will wear the appropriate radiation safety monitor during applicable timeframes, and never both at one time.

   Student Signature _____

   cc: Program Director; Departmental Student File; original kept in clinical notebook