J.W. Mitchell High School
ACADEMY for the MEDICAL ARTS
Senior Shadowing Project Information

*Please submit this to **Ms. Schultz**, Assistant Principal for the Academy for the Medical Arts.*

Name: ____

Home Address: ____

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Contact Phone: __________________________ E-Mail: ______________________________________

Location of Shadowing

Directions: Please describe where you completed your shadowing project. Please include the location name, physician information, and address and phone number. If a website for the location exists, please include that as well.

Responsibilities/Activities During Shadowing

Directions: Please describe what you were responsibilities and activities during shadowing. Include how many hours approximately you spent with each responsibility/activity.

Statement of Understanding

I have completed the project in its entirety. I understand that completion of this activity is one of the qualifications to graduate with Academy for the Medical Arts Honors.

Student Signature: ____ Date:_______________

AP Signature: ____ Date:_______________