

Clinical Visit Feedback Form

BSc (Hons) Radiography (Radiotherapy and Oncology)

This form should be completed by the Radiographer in charge of the unit or area.

Applicant's name:

Applicant's UCAS Personal ID:

Name of hospital visited: Date of visit:

Number of hours spent in the department:

Please indicate below which areas / specialties / procedures / techniques the applicant has seen during this visit:

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> radical breast techniques | <input type="checkbox"/> simulator |
| <input type="checkbox"/> radical pelvis techniques | <input type="checkbox"/> CT Sim |
| <input type="checkbox"/> radical head and neck techniques | <input type="checkbox"/> CT Scanner |
| <input type="checkbox"/> planning | <input type="checkbox"/> mould room |

Other:

Please consider the suitability of this applicant for a career in Therapeutic Radiography:

	Very good	Acceptable	Poor
Punctuality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal presentation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professional manner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of background reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Apparent interest during visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other comments:

Radiographer's signature:

Radiographer's name (PLEASE PRINT):

Radiographer's position:

Please return this form to the applicant once completed. Thank you for your time.

Note to applicant: please return this form to health@city.ac.uk

It is strongly recommended that you keep a copy of this form for your own records.