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:

- [ ] radical breast techniques  [ ] simulator
- [ ] radical pelvis techniques  [ ] CT Sim
- [ ] radical head and neck techniques  [ ] CT Scanner
- [ ] planning  [ ] mould room

Other: ........................................................................................................................................................................................................

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

Punctuality

- [ ] Very good
- [ ] Acceptable
- [ ] Poor

Personal presentation

- [ ]

Professional manner

- [ ]

Evidence of background reading

- [ ]

Apparent interest during visit

- [ ]

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.

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