

Jefferson State Community College
Diagnostic Medical Sonography Program
Observation Form

{This form must be completed in its entirety and submitted with your DMS application.}

Applying for DMS Program Beginning: _____

Student Name _____

A number _____

Facility Name	Date mm/dd/yyyy	Time In	Time Out	Hour(s)	Name of Sonographer	Signature of sonographer	Certification # of Sonographer

Please type or print legibly in black ink