## Confirmation of Experience to Participants

Dear Surgical Subspecialty Experience Program (SSEP) Member,

We are contacting you to confirm your appointment to shadow on **[DATE]** from **[START TIME]** to **[END TIME]**. You will be observing **[PHYSICIAN NAME], [SPECIALTY]** in [**OR NUMBER/CLINIC LOCATION]**. Directions to the OR/Clinic can be found on **[DIRECTIONS TO OR/CLINIC URL]**.

**If for any reason you need to cancel your appointment, please notify us no less than 12 hours before your scheduled start time.**

You will also receive an email with a link to complete an evaluation following your shadowing experience.

Thank you for taking advantage of the SSEP Program and please do not hesitate to contact us if you have any questions!

Sincerely,

The SSEP Team