UNIVERSITY OF THE PACIFIC

VERIFICATION OF CLINICAL OBSERVATION HOURS

Dear Athletic Trainer,

Thank you for allowing students to gain valuable clinical observation experience and verifying these hours for students applying to our Athletic Training program.

Please complete this form, print, sign and return to the applicant.

Applicant Name: _____

Please indicate the number of clinical athletic training hours and location where this student completed clinical observation hours under the **Direct Supervision** of a current Board of Certification (BOC) Certified Athletic Trainer. Direct supervision requires that the athletic trainer must be physically present and have the ability to intervene on behalf of the student and the patient.

Number of clinical hours: _____ Locations: _____

Please provide inclusive dates in which the applicant completed the clinical hours.

From: _____ To:_____

Please indicate the type of work performed during their clinical hours. (Please be specific. If necessary, use additional Word document.)

Athletic Trainer: _____ BOC Number: _____

_____ _____

Ink signature Date