HEALTH PROFESSIONS
ATHLETIC TRAINING
CENTRAL MICHIGAN UNIVERSITY

VERIFICATION OF CLINICAL OBSERVATION HOURS

The intent of this form is to verify that the below named student has completed the identified number of hours with you and your agency.

Student's Name: _____

Athletic Trainer's Name and Credentials: _____

Agency: _____

Telephone: _____ Email: _____

Total Number of Hours Accumulated: _____

I verify that the above mentioned information is true to the best of my knowledge.

Athletic Trainer's Signature: _____

Title: _____ Date: _____