

Please print, complete and sign this form.



VERIFICATION OF CLINICAL HOURS

Thank you for your willingness to verify clinical hours for the applicant who is applying to SUNY Cortland's graduate program in athletic training. Please indicate the number of clinical athletic training hours and the location where this applicant worked under the direct supervision of a currently BOC-certified athletic trainer. Direct supervision requires that the athletic trainer is physically present and has the ability to intervene on behalf of the student and the patient.

Applicant name:		
Number of hours:	Location:	
Please provide dates in which the students From:	dent completed the observation hours To:	
Name of certified athletic trainer:		(please print)
BOC certification number:		
I verify that the above applicant has a the definition of direct supervision.	ccumulated the number of clinical ho	urs indicated above in accordance with
Signature	Date	