



Observation Hours Verification Form

Applicant name: _____

Supervising Athletic Trainer information:

Name:		BOC number:	
Email:		Organization:	
Phone:		Job Title:	

Date/Range of Observation: (e.g. Jan-March 2023)	
Total Hours Observed:	
Location/Practice setting:	<input type="checkbox"/> Secondary school athletics <input type="checkbox"/> Collegiate athletics <input type="checkbox"/> Clinic (rehabilitation) <input type="checkbox"/> Clinic (physician) <input type="checkbox"/> Other, please describe: _____
Description of observation and/or duties:	
If you have any comments about the student or observation experience, please share here (optional):	

I verify that the student named above completed the hours specified under my direct supervision.

Supervising AT signature (electronic/typed is ok)

Date

Please upload the completed Hours Verification Form to ATCAS.