Master of Science in Athletic Training

Observation Hours Verification Form

Please use this form to record the completion of a minimum of 60 observation hours under a Certified Athletic Trainer.

Applicant Name (First, Last): ______________________________________________________________

Date: ________________________

Location of Observation (Institution, City, State): _____________________________________________

Type of AT Setting (Please Check):

- High School
- College; Level: _________
- Clinic/Hospital
- Industrial/Factory
- Military/Police/Fire
- Performing Arts
- Other: ________________

Observation Time Period (include month, days and year): ______________________________________

Total Hours Completed: ___________________________________________________________________

Briefly summarize observation experiences:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Name of Supervising AT (Please Print): _____________________________________________________

Signature of Supervising AT: ___________________________ Date _________________________

Supervising AT’s BOC #: __________________________________________

State License/Registration # (if applicable): ________________________________

By signing this form, you attest that the applicant has completed observation hours under your supervision.

*You may use multiple copies of this form if you have observed at additional locations.