Master of Science in Athletic Training

Observation Hours Verification Form

Please use this form to record the completion of a minimum of 50 observation hours under a Certified Athletic Trainer.

Applicant Name (First, Last): ____________________________________________________________

Date: ____________________________

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

Type of AT Setting (Please Check):

   o High School
   o College; Level: _________
   o Clinic/Hospital
   o Industrial/Factory
   o Military/Police/Fire
   o Performing Arts
   o I participated as a varsity collegiate athlete with my AT at that institution
   o Other: ____________________

Observation Time Period (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.