TEXAS A&M UNIVERSITY CORPUS CHRISTI | ATHLETIC TRAINING PROGRAM

Master of Science in Athletic Training

Verification of Athletic Training Observation Hours

Student Name: _____ Date: _____
First Name Last Name

Please use this form to record the completion of a minimum of **50** observation hours in Athletic Training.

Name of Athletic Trainer Supervising Hours: _____

BOC Certification #: _____

Email Address: _____

Phone Number: _____

Facility Name: _____

Facility Location (City, State): _____

Signature of AT Verifying Hours: _____

Observation Time Period (include month and year): _____

Total Hours Completed: _____

**If you maintain observation hours in another format you may substitute your current form if the information above is provided.*

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

TEXAS A&M UNIVERSITY CORPUS CHRISTI

ATHLETIC TRAINING PROGRAM

Student Name: ____
First Name Last Name

Date of Observation	Hours Completed