



SUNY BROCKPORT

Athletic Training Program

Verification of Athletic Training Observation Hours

Thank you for your willingness to verify clinical observation hours for the applicant who is applying to SUNY Brockport's graduate program in athletic training. Please complete the form below and 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.

Please print, complete and sign this form.

Applicant name: _____

Location: _____

Number of completed hours: _____

Please provide dates in which the student completed the observation hours.

From: _____ To: _____

Name of certified athletic trainer: _____ (please print)

BOC certification number: _____

I verify that the above applicant has accumulated the number of clinical observation hours indicated above in accordance with the definition of direct supervision.

Athletic Trainer Signature: _____

Date: _____