COLLEGE OF GRADUATE STUDIES
ANGELO STATE UNIVERSITY

Athletic Training Volunteer Hours

Complete this form and email it to bshsp@angelo.edu

(Use one sheet for each facility)

Student Name: _____ CID# or SS#:_____

Facility (no abbreviations): _____

Address: _____

City State Zip

Facility Phone: ( ) _____ Fax: ( ) _____

Type of Facility: (Check all areas where you observed at this facility)

___ Hospital ___ Sports Medicine Clinic ___ School System
___ Recreational Center ___ Industrial Rehab Center ___ Private Practice
___ Collegiate Athletics ___ Other (specify) _____

Patient Age Range:

___ Elementary/Middle School Students ___ High School Students ___ College Students
___ Adult Patients (25-49 years) ___ Adult Patients (50+)

Clinical Experiences: Briefly list the types of programs and the number of hours you specifically observed. (Examples: high school athletic events and treatments, preventative treatment and rehabilitation, post-surgical treatment and rehabilitation, wound care, orthopedic diagnosis, emergency care, etc)

Observed	Dates	Total Hours	Supervisor's Initials

Total Number of Hours of Observation: _____

Student Signature: _____ Date: _____

Athletic Trainer's Signature: _____ Date: _____

Please Print Athletic Trainer's Information:

_____ _____ _____

Name Title Licensure Number