Child Life Practicum Student Application

Hour Verification Form

I, ___________________________, verify that ______________________________

(Print Name) (Applicant's Name)

has completed ______ hours of working with (Circle one): Well Children

(# of hours) Hospitalized

at ____.

(Name of organization)

Description of Responsibilities:

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____________________________________ ___________________

(Print Name) (Title/Credentials)

____________________________________ ___________________

(Signature of person completing form) (Date)

____________________________________ ___________________

(Signature of applicant) (Date)