



SCHOOL OF HEALTH  
AND MEDICAL SCIENCES  
*Athletic Training*

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# SETON HALL UNIVERSITY

## Clinical Observation Hours Verification Form

*Make additional copies of this form as needed to complete the fifty hour requirement. Observation hours must be completed within five (5) years of application date.*

This is to verify that \_\_\_\_\_ has completed \_\_\_\_\_ hours  
(Name)  
with me at \_\_\_\_\_.  
(Name of facility)

\_\_\_\_\_  
Name and credentials (please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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This is to verify that \_\_\_\_\_ has completed \_\_\_\_\_ hours  
(Name)  
with me at \_\_\_\_\_.  
(Name of facility)

\_\_\_\_\_  
Name and credentials (please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date