

DEPARTMENT OF FAMILY AND CONSUMER SCIENCES
CLINICAL OBSERVATION/SERVICE LEARNING
VERIFICATION FORM

NAME: _____

AREA OF STUDY: _____

COOPERATING SUPERVISOR: _____

AGENCY/ORGANIZATION/BUSINESS: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

CONTACT PHONE NUMBER: _____

DATE	TIME IN	TIME OUT	TOTAL TIME	SUPERVISOR SIGNATURE

TOTAL HOURS: _____ (5 Hours is the Minimum Requirement)

Student Signature

Supervisor Signature