Verification of Patient Care Experience

Applicants to the Diagnostic Medical Sonography program must provide verification of patient care experience. **Please have your supervisor complete the following information in its entirety.**

Name of applicant

1. Total hours of involvement this applicant has had at your facility? _____

2. Please list the main duties of this individual (or attach a copy of the job description):

3. How would you rate this individual's overall performance?

◯ Exceptional ◯ Very good ◯ Average

Name / Title of person completing form (please print or type)

Organization

Phone number E-Mail