TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
School *of* Medicine

HEALTHCARE RELATED/VOLUNTEERING ACTIVITY CONFIRMATION FORM

Academic Year _____ Undergraduate Institution _____

Total number of hours worked _____ Matriculation year:_____

Activity start date:_____ Activity end date:_____

Department or Organization where work was done:

_____

Address: _____

Phone:_____

Description of activity performed: _____

_____

_____

I hereby acknowledge that the work as described above has been satisfactorily and fully completed and that no monetary remuneration was paid to_____
Name of Student (please print)

Name: _____ Title: _____
Supervisor (please print)

Email: _____ Phone number: _____

_____ _____
Supervisor's Signature Date:

Student's Name: _____
(please print)

_____ _____
Student's Signature Date:

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