Diagnostic Medical Sonography Program
Volunteer Hours Form

INSTRUCTIONS:

1. Please act professionally and be courteous.
2. All volunteer hours must be completed within 12 months of applying to the program.
3. Upon completion, please scan the completed form and email to DMSprogram@clarkstate.edu.

STUDENT INFORMATION:

First and Last Name: _____

Student ID #: _____

VOLUNTEER HOURS:

The individual named above has **completed** _____ **volunteer hours** at the organization noted below.

Name of Organization: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Date(s) of Service: _____

Please describe the volunteer work that was done:

SUPERVISOR'S INFORMATION:

Supervisor's First and Last Name: _____

Supervisor's Title: _____

Email: _____ **Phone Number:** _____

By signing this form you acknowledge the student has completed the volunteer hours described above.

Supervisor's Signature: _____ **Date:** _____

For additional comments and concerns about this student, please email Megan Platfoot, Assistant Professor and Program Coordinator, at platfootm@clarkstate.edu.