



FIELDWORK EXPERIENCE VERIFICATION FORM UNDERGRADUATE CLINICAL EXPERIENCE

INSTRUCTIONS: Complete all sections of the form and submit to college or university for verification and for signature by current training program director/coordinator.

APPLICANT'S NAME: _____

UNIVERSITY OR COLLEGE: _____

LOCATION WHERE EXPERIENCE WAS OBTAINED	DATES OF EXPERIENCE FROM (MO/YR) TO (MO/YR)		HOURS EARNED
GRAND TOTAL:			

I certify that all fieldwork experiences listed on this form were completed according to the State of California requirements. I further certify under penalty of perjury under the laws of the State of California that all statements made herein are true in every respect.

 NAME OF CURRENT TRAINING PROGRAM DIRECTOR/COORDINATOR

 DATE

 SIGNATURE OF CURRENT TRAINING PROGRAM DIRECTOR/COORDINATOR

 DATE

 APPLICANT'S SIGNATURE

 DATE