MOUNT ST. JOSEPH
UNIVERSITY
Master of Athletic Training

MOUNT ST. JOSEPH ATHLETIC TRAINING PROGRAM
MAT OBSERVATION HOURS VERIFICATION FORM

To be completed by Applicant:

Applicant Last Name _____ First Name_____

Address _____

Phone _____ Email _____

Athletic Trainer Name _____

Employer _____

Type of Practice _____

Date(s) Observed _____

Describe your AT observation experience, types of patients seen, and the duties of the AT:

To be completed by Athletic Trainer:

I verify that _____ observed me as indicated above.
(Name of Applicant)

Signature _____, ATC Date _____

Name (printed) _____, ATC

BOC ID _____ NPI #_ _____

Please check if interested:

☐ Yes, I am interested in being a preceptor for a MSJ MAT student; contact me by

Phone: _____ Email: _____