ALAMO COLLEGES DISTRICT
St. Philip's College

Diagnostic Medical Sonography Program
Volunteer Hours Form

Applicant/Volunteer Name (Please Print) _____

Volunteer Healthcare Organization _____

This form documents that_____**has completed volunteer (*)**

hours with our organization_____**. These hours were**

completed as listed below.

Hours per week _____ **Date** _____
Hours per month _____ **Date** _____

TOTAL
HOURS_____

Duties included: _____

_____

Supervisor name/Title _____

Address of Organization _____

Contact information _____

Signature _____

The previous information regarding my volunteer hours is accurate and valid.

Applicant signature_____**Date** _____

(*) "Volunteer" hours are defined as time spent in a true volunteer status, where there was NO financial compensation received by the applicant for any of the time that was spent volunteering. Verification of work accomplished will be validated by Diagnostic Medical Sonography Admission committee. Feel free to attach any additional documents.