Department of Family Studies and Community Development
Child Life, Administration and Family Collaboration (M.S.)
Application Form C: Volunteer/Work Experience Verification Form

INSTRUCTIONS FOR COMPLETING THIS FORM

*** This form is a fillable PDF form. It must be opened and completed using Adobe Reader. This free software may be downloaded from the Adobe website.**

*** Please provide all of the information requested on this form.**

*** When completing the date fields on this form, please provide the dates in the MM/DD/YYYY format.**

*** You may save your partially or totally completed Form C to your computer by clicking on File > Save As and entering a name for the file in the Save As dialog box. This saved version may be reopened at a later date and worked on again.**

*** When your form is ready, click on Print to print the copy that will be signed and submitted.**

GENERAL INFORMATION

Last Name of Volunteer: _____

First Name of Volunteer: _____

Hours of Volunteer/Work Experience Completed: _____ Institution: _____

City of Institution: _____ State of Institution: _____

Type of Experience:
- ☐ Intern/Volunteer
- ☐ Fellowship
- ☐ Paid Work

Start Date: _____ End Date: _____

By signing below, I verify that the above individual completed the stated hours of volunteer/ work experience with children and families with special health care needs.

Signature with Credentials:

Printed Name:

Date:

Title:

Work Address:

Phone Number:

E-mail: