TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™

School *of* Medicine

HEALTHCARE RELATED/VOLUNTEERING ACTIVITY CONFIRMATION FORM

Academic Year _____ Undergraduate Institution _____

Total number of hours worked _____ Matriculation year:_____

Activity start date:_____ Activity end date:_____

Department or Organization where work was done:

_____

Address: _____

Phone:_____

Description of activity performed:_____

_____

_____

I hereby acknowledge that the work as described above has been satisfactorily and fully completed and that no monetary remuneration was paid to_____
Name of Student (please print)

Name: _____ Title: _____
Supervisor (please print)

_____ _____
Supervisor's Signature Date:

Student's Name: _____
(please print)

_____ _____
Student's Signature Date:

Return form to:

Texas Tech University Health Sciences Center
School of Medicine - Admissions
3601 4th Street, MS 6216 | Lubbock, Texas 79430

Or email to:

somadm@ttuhsc.edu