Direct Service Hours Verification

Submitted by: _____ Date: _____

Number of hours accumulated: _____ Job Title: _____

Name of school/clinic/private practice: _____

Year range in which you accumulated the Hours:_____

During these hours, I performed the following Educational Therapy related activities:

Verified by:

◯ Work site Administrator. ◯ Professional Supervisor ◯ Colleague

◯ Other _____

Verifying Signature: _____

OR

☐ I am submitting this letter electronically and indicate by this check that I am the person named above as verifying this document.

Name of Person Verifying Hours: _____

Title: _____

Email Address: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____ Phone: _____