Foothill College
Diagnostic Medical Sonography Program
Direct Patient Care Experience (DPCE) – Verification Form

The individual listed below has applied for admission into the Foothill College Diagnostic Medical Sonography Program and has identified your business/company as a previous place of employment (or volunteering) in which direct patient care was a part of their duties. Please complete the requested information to verify the information.

(Applicant should complete this portion, and request supervisor to verify and sign)

Applicant Name: _____

Business/Company Name: _____

Applicant Job Title: _____

Dates of employment (or volunteering): _____ **to** _____

Average weekly hours: _____

Supervisor's Printed Name: _____

Supervisor's phone: _____

Supervisor's email: _____

List of duties as they apply to direct patient care (example: vital signs, patient transfer, patient prep, etc)

_____

_____

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_____

Supervisor's Signature _____ **date** _____

I, _____ **(applicant name) attest the above information is true and accurate. I give consent for Foothill College Diagnostic Medical Sonography program to verify the above information with the previous employer listed above. I understand that discrepancy in the information may disqualify my application from the diagnostic medical sonography program.**

Applicant Signature _____ **date** _____

Return the form to schaferali@fhda.edu Subject Line: DMS Direct Patient Care Form