

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

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

(Applicant should complete this portion, and request the 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)

Supervisor's Signature _____ date _____

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

Applicant Signature _____ date _____

Upload the form directly to the DMS Application located in MyPortal > Allied Health Card