Michael E. DeBakey High School for Health Professions

Student Volunteer Hours Verification

Date: _____

Student Name: _____

Grade: _____

Activity: _____

Location of Activity: _____

Address of Activity: _____

Phone Number of Activity: _____

Number of Hours Worked: _____

Contact Person – Print Name: _____

Signature of Contact Person: _____

_____

HAND DELIVER THIS FORM TO YOUR REGISTRAR (Mrs. Shannon Niaves) Room 123