

**University of Texas Health Science Center at San Antonio
School of Allied Health Sciences
Doctor of Physical Therapy Program
Service Hours Log**

Student Name: _____

Date: _____ **Supervisor's Signature:** _____

Hours: _____

Organization and Activity	Check one below: On Campus ____ Off Campus ____
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Cumulative Hours: On Campus _____ Off Campus _____

Date: _____ **Supervisor's Signature:** _____

Hours: _____

Organization and Activity	Check one below: On Campus ____ Off Campus ____
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Cumulative Total Hours: On Campus _____ Off Campus _____

Date: _____ **Supervisors Signature:** _____

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