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 place of employment where direct patient care was part of their job responsibilities.

This form is used to verify that the applicant has met the program's direct patient care experience (DPCE) requirement of a minimum of two (2) years of experience, with at least 1,500 hours worked per year (minimum total of 3,000 hours). The applicant is not required to submit a full employment history—only sufficient documentation to verify that the minimum hour requirement has been met.

Applicant Information (To be completed by applicant)

Applicant Name: _____

Business/Company Name: _____

Job Title: _____

Dates of Employment: From _____ To _____

Average Weekly Hours Worked: _____

Estimated Total Hours Worked During This Employment Period: _____

Verification of Direct Patient Care Duties (To be completed by employer/supervisor)

Please list the applicant's responsibilities that involved direct patient care (examples include but are not limited to: vital signs, patient transfers, patient preparation, assisting with procedures, direct patient interaction, etc.).

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Employer/Supervisor Verification

I certify that the information provided above is accurate and reflects the applicant's direct patient care experience.

Supervisor/Manager Printed Name: _____

Title: _____

Phone Number: _____

Email Address: _____

Supervisor/Manager Signature: _____ Date: _____

Proof of Hours Worked (Required)

The applicant must submit a copy of a pay stub or equivalent employer-issued documentation that reflects hours worked and corresponds to the employment period listed above. Documentation is required solely to verify that the minimum 1,500-hour-per-year requirement has been met.

Applicant Attestation

I, _____ (applicant name), attest that the information provided on this form is true and accurate. I authorize the Foothill College Diagnostic Medical Sonography Program to verify this information with the employer listed above. I understand that any false or misleading information may result in ineligibility for admission.

Applicant Signature: _____ Date: _____

This completed form and required documentation must be uploaded to the DMS Application in MyPortal under the Allied Health Card section. Please review the DMS Online Application Instructions for additional details.