

Graham Hospital School of Nursing

Community Service Hours Report Form

Student Name: \_\_\_\_\_

Class of \_\_\_\_\_

Date of Service	
Service Site	
Detailed Description of Service or Beneficiary of Service	
Hours of Service	

Agency Representative Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
(printed)

Agency Representative Signature: \_\_\_\_\_

I certify that the above information was completed in good faith and is correct to the best of my abilities.

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Approved: 5/23/12

Revised: 8/20/12

Reviewed: 5/19/14, 5/22/15, 5/23/16, 5/23/17, 4/16/18, 4/22/19, 4/20/20, 4/19/21-A&R