THOMPSON RIVERS UNIVERSITY

Respiratory Therapy Program

HOSPITAL TOUR VERIFICATION FORM

NAME (Please Print)	STUDENT ID #(if applicable)	SIGNATURE

_____   _____
Name of RRT (print)   Name of RRT (Signature)

_____   _____
Name of Hospital   Date

Please return completed form to:
Ornella Falsetta, Admissions/Records Officer
ofalsetta@tru.ca
Thompson Rivers University
900 McGill Road
Kamloops BC V2C 0C8

O:\Group Share\Resp Therapy\Template\Verification Form Program Info Sessions.