Official Company Letterhead

Street Address, City, ST ZIP Code
Telephone
Email

Date

Dear DMS Application Selection Committee,

The following applicant (**APPLICANT'S FULL NAME**) started with our organization on (**DATE**). The following is a list of the duties required for the Direct Patient Care portion we provide to our patients:

(**List each duty that involved Direct Patient Care**)

The total number of paid/volunteer hours submitted to date _____.

Warm regards,

Reporting RN or MD Signature
Printed name, Title
Contact Phone Number

E-Mail Address