Athletic Training Program

28-Hour Clinical Log

Name: ____________________________ Semester/ Year: __________________

Preceptor: _________________________ Rotation: ________________________

Clinical Site: ______________________ Week:___ / ___ / ___ - ___ / ___ / ___

Day of Week & Date	Time In/Time Out	Hours	Preceptor Initials

I certify that the record of hours above is correct for the dates indicated.

I certify that the clinical experience hours recorded on this form have been documented under my direct supervision.

____
Student's Signature

____
Preceptor's Signature

____
Date

____
Date