Athletic Training Program  
Request for Additional Clinical Experience Hours

Name: __________________________  Date of Request: ________________
Preceptor: ______________________  Clinical Assignment: _____________
Total number of weekly hours thus far: _________ Hours requested: _________

Number of clinical hours for the week (Hours thus far + additional hours) = ________
Reason for request: ________________________________________________________

________________________________________________________________________

Student’s Signature __________________________________ Date

Preceptor’s Signature __________________________________ Date

*Student and Preceptor must approve the additional hours prior to submission to the
Clinical Education Coordinator.

________ Approved ________ Denied

Clinical Education Coordinator ______________________ Date

Reason for denial: ____________________________________________________________