



**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: \_\_\_\_\_

\_\_\_\_\_