

Monthly Clinical Experience Time Record
 (Record to the *nearest 1/4 hour* and provide weekly and cumulative totals.)

Month: _____

Level of Student: _____

Name of ATS: _____

Clinical Rotation Assignment: _____

DATE	Description of Activities	Clinical Education Hours					Daily Total Hours	Weekly Totals <small>(Use this column to add all of your daily hours)</small>	ACI/CI Initial
		Time In	Time Out	Time In	Time Out				
Mon									
Tues									
Wed									
Thur									
Fri									
Sat									
Sun									
Total Weekly Hours									
Mon									
Tues									
Wed									
Thur									
Fri									
Sat									
Sun									
Total Weekly hours									
Mon									
Tues									
Wed									
Thur									
Fri									
Sat									
Sun									
Total Weekly Hours									
Mon									
Tues									
Wed									
Thur									
Fri									
Sat									
Sun									
Total Weekly Hours									

Message to student:

Sign in the space below before you give this form to your ACI/CI. Your signature indicates that you logged your hours accurately.

ATS Signature _____ Date _____

Message to ACI/CI:

Please provide comments concerning this student's progress in the space below. After adding comments, sign your name in the space provided and then either hand deliver to room 212 of McKenzie Arena or send with the student in a sealed and signed envelope.

Comments:

Signature of Clinical Instructor _____ Date _____

ATEP Director Signature _____ Date _____