

Monthly Clinical Experience Time Record

Month: _____

Name of ATS: _____ Level of Student: _____

Date	Clinical Assignment Description of Activities	Time In	Time Out	Time In	Time Out	Daily Total Hours	Weekly totals
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
Sunday							
Total Weekly Hours							

Signature attests to the fact the student's hours recorded above are correct to the best of your knowledge.

ACI/CI Signature _____

Date	Clinical Assignment Description of Activities	Time In	Time Out	Time In	Time Out	Daily Total Hours	Weekly totals
Monday							
Tuesday							
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Signature attests to the fact the student's hours recorded above are correct to the best of your knowledge.

ACI/CI Signature _____