TODAY'S DATE	CLINICAL SITE (List facility)	PRECEPTOR	TIME IN	TIME OUT	Experience Type/Description (check all that apply)							DAILY TOTAL HOURS	PRECEPTOR INITIALS
					Protective Equipment	Conditions other than Ortho	Male	Female	Individual	Team	Non-Sport Population		

I certify that the hours recorded on this form have been accepted and entered into the student's record.

_____, ATC _____

(Program Director's Signature) (Date)

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