ATHLETIC TRAINING STUDENT (ATS) CLINICAL HOURS RECORD
(General Medical Experience w/ Physician or Nurse Practitioner)

ATS Name: _____

Level: (circle one) **So Jr Sr** **Semester:** (circle one) **Fall J-term Spring** **Year** _____

Date (Month/ Day/ Year)	**Hours**
_____	_____
_____	_____
_____	_____
_____	_____

_____ **- Total Hours**

Physician/ Practitioner Signature: _____ **Date:** _____

Student Signature: _____ **Date:** _____

Comments (Progress, compliance, etc.):

Program Director Signature (Indicating Approval): _____

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