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):


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

<table>
<thead>
<tr>
<th>ATS Name: ________________________________</th>
<th>Level: (circle one) So Jr Sr</th>
<th>Semester: (circle one) Fall J-term Spring</th>
<th>Year ________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date (Month/ Day/ Year)</td>
<td>Hours</td>
<td>Date (Month/ Day/ Year)</td>
<td>Hours</td>
</tr>
<tr>
<td>___________________</td>
<td>________</td>
<td>___________________</td>
<td>________</td>
</tr>
</tbody>
</table>

_____ - Total Hours

Physician/ Practitioner Signature: ____________________________ Date: ________________

Student Signature: ____________________________ Date: ________________

Comments (Progress, compliance, etc.):

Program Director Signature (Indicating Approval): ____________________________

---

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

<table>
<thead>
<tr>
<th>ATS Name: ________________________________</th>
<th>Level: (circle one) So Jr Sr</th>
<th>Semester: (circle one) Fall J-term Spring</th>
<th>Year ________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date (Month/ Day/ Year)</td>
<td>Hours</td>
<td>Date (Month/ Day/ Year)</td>
<td>Hours</td>
</tr>
<tr>
<td>___________________</td>
<td>________</td>
<td>___________________</td>
<td>________</td>
</tr>
</tbody>
</table>

_____ - Total Hours

Physician/ Practitioner Signature: ____________________________ Date: ________________

Student Signature: ____________________________ Date: ________________

Comments (Progress, compliance, etc.):

Program Director Signature (Indicating Approval): ____________________________