**For each Clinical Experience Site, you will need to complete this form. You may have more than one form. Please print in INK the following:**

|  |  |
| --- | --- |
| **Applicants Legal Name:** |  |
| **Supervising AT (ATC/LAT) and Title** |  |
| **Name, Address, and Phone Number of the Clinical Setting** |  |

|  |  |  |
| --- | --- | --- |
| **Month/Day/Year** | **Description of Experience** | **Hours Accrued** |
| **\_\_\_/\_\_\_/\_\_\_** |  |  |
| **\_\_\_/\_\_\_/\_\_\_** |  |  |
| **\_\_\_/\_\_\_/\_\_\_** |  |  |
| **\_\_\_/\_\_\_/\_\_\_** |  |  |
| **\_\_\_/\_\_\_/\_\_\_** |  |  |
|  | **Total Hours Accrued at this site** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**By signing this document, I attest that the documented hours and the information are correct and accurate.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Applicants Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ATC/LAT Signature Date**

BW3/19