

**East Texas Baptist University
Athletic Training Education Program
Clinical Experience Record**

Name: _____ **Semester / Year:** _____ **Practicum Course #:** _____

Date	Clinical Experience Area	Hours	Skills Utilized

Total Hours / wk: _____

Student Signature: _____ **ACI / CI Signature:** _____ **Date:** _____

*** This form should be turned in to your Practicum instructor Tuesday of each week for grade recording. Forms not received by 8:00 am on Tuesday will not be considered for grading purposes. Those forms that do not list the 16 required hours will receive no credit for the week.**