School of Health and Human Sciences
Radiation Therapy Clinical Observation Log
One location per form

Name:_____

Location: _____

Date:_____
Time:_____ Hours:_____

Date:_____
Time:_____ Hours:_____

Date:_____
Time:_____ Hours:_____

Date:_____
Time:_____ Hours:_____

Applicant
Signature:_____Date:_____

Clinical Supervisor:_____Date:_____
Phone Number _____