Athletic Training Program

COLLEGE OF NURSING AND HEALTH INNOVATION

# The University of Texas at Arlington
# Master of Science in Athletic Training Program
## Clinical Observation Log

**Applicant Information**

Name:

Application for Entry in Summer 20

Email:

Phone:

**Supervising Athletic Trainer**

Name:

Title:

Email:

Phone:

| Date | Description of Experience (event, conditions seen, etc.) | Time In/Out | Total |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| | | | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| TOTAL OBSERVATION HOURS | | | |

Signature of Applicant _____ Date

Signature of Athletic Trainer _____ Date