WHEELING UNIVERSITY

Master of Science of Athletic Training

Clinical Observation Experience Form (Minimum of 50 Hours)

**Use additional sheets if needed*

Please provide the following information:

Name of Observation Site:	
Date(s) of Observation:	
ATC Professional Observed:	
Credentials:	
License #:	
Employer:	
Phone Number:	
Email:	
Total Hours Observed:	

Please check the box that corresponds with the setting of this Observation Site:

☐ Secondary
☐ Collegiate
☐ Professional
☐ Rehabilitation Clinic
☐ Hospital
☐ Physician Office
☐ Other: ______________________________

Please check the box that corresponds with the patient population (check all that apply):

☐ Orthopedics
☐ Neurological
☐ Cardiovascular
☐ Integumentary
☐ Geriatrics
☐ Pediatrics
☐ Athletics
☐ Other: ______________________________

Supervising ATC Signature: ____ **Date:** ____________________

Student Signature: ____ **Date:** ____________________