Waynesburg University
Masters 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 of Observation:	
ATC Professional Observed:	
Credentials:	
License #:	
Employer:	
Phone Number:	
Email:	
Total Hours observed:	

Please check the box that corresponds with this location's setting:

- ❑ Secondary
- ❑ Collegiate
- ❑ Professional
- ❑ Rehabilitation Clinic
- ❑ Hospital
- ❑ Physician office
- ❑ Other:_____

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

- ❑ Orthopedic
- ❑ Neurological
- ❑ Cardiovascular
- ❑ Integumentary
- ❑ Geriatrics
- ❑ Pediatrics
- ❑ Athletics
- ❑ Other:_____

Overseeing ATC Signature:_____ **Date:_____**

Student Signature:_____ **Date:_____**