Athletic Training
Observation Hours

Observer Name:_____

Signature:_____

Date:_____

Supervisor Name:_____

Signature:_____

Date:_____

E-mail:_____

Phone Number:_____

BOC Number:_____

State Licensure Number:_____

Name and Location of Clinical Site(s): _____

☐ Secondary School ☐ Collegiate ☐ Pro/Semi-Pro ☐ Tactical ☐ General Population

☐ Competition ☐ Practice ☐ Clinic ☐ Other:_____

☐ Equipment Intensive ☐ Rehabilitation ☐ Other: _____

Date	Hours	Date	Hours	Date	Hours	Date	Hours	Date	Hours	Date	Hours
Total											
Overall Total											

Observer Name: _____

Date	Hours	Date	Hours	Date	Hours	Date	Hours	Date	Hours	Date	Hours
Total											
Overall Total											