Hours of observation form for admission criteria.

TEXAS STATE UNIVERSITY

The rising STAR of Texas

Master of Athletic Training Program
Clinical Observation Log Sheet
DEPARTMENT OF HEALTH AND HUMAN PERFORMANCE

Print Applicants Legal Name:_____
Print Supervising AT (ATC/LAT) and Title:_____
Name, Address of Phone Number of Clinical site:_____
**For each Clinical Experience Site, you will need to complete this form.

Week	Dates	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Total Hours	Preceptor Initials
EXAMPLE	**01/01/2026-01/07/2026**	**OFF**	**1-5pm**	**1-5pm**	**1-5pm**	**OFF**	**1-5pm**	**OFF**	**20**	**BKPW, ATC/LAT**
Weekly Summary	**Describe your week here**									
1										
Weekly Summary										
2										
Weekly Summary										
3										
Weekly Summary										
4										
Weekly Summary									**Monthly Total of hours ->**	

TOTAL PATIENT EXPOSURES FOR THE MONTH__#_____

Supervising AT Signature:_____ Date: _____

Student Signature:_____ Date:_____