



# Master of Science of Athletic Training Program Clinical Experience Documentation Form

This form is required to document the applicant's experiences in an athletic training environment. It is not a recommendation form. Students are required 25 hours in an athletic training setting. Hours may be obtained in one or multiple settings. If multiple settings, please use a separate form for each setting.

### APPLICANT SECTION:

Applicant's name (print) \_\_\_\_\_ Carroll ID # (If known) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Email Address \_\_\_\_\_

Release of access to document:

The applicant must complete and sign the following before submitting this form to the reference. This request is in compliance with Federal Law P.L. 9380, Family Education Rights and Privacy Act of 1974.

- I waive my right of access to this document.
- I do not waive my right of access to this document.

Applicant's signature \_\_\_\_\_

### CERTIFIED ATHLETIC TRAINER SECTION:

The above individual is applying for admission into the Master of Science of Athletic Training Program at Carroll University, Waukesha, WI.

Instructions: Please complete this clinical experience documentation form and return the document to the applicant or to Carroll University Office of Admission 100 North East Avenue, Waukesha, WI 53186 or email a scanned copy to [gradinfo@carrollu.edu](mailto:gradinfo@carrollu.edu). Note: If the applicant selects to waive their right of access please place in a sealed envelope with the certified AT signature across the seal.

The applicant has spent \_\_\_\_\_ hours in [ ] observation; \_\_\_\_\_ hours in [ ] volunteer, and/or \_\_\_\_\_ hours in [ ] employment at my facility.

Total Hours: \_\_\_\_\_

Dates of Attendance: \_\_\_\_\_

Indicate the number of hours and practice setting where the applicant observed:

#### SETTING:

- High School [\_\_\_\_ hrs.]
- College [\_\_\_\_ hrs.]
- Outpatient Rehabilitation Clinic [\_\_\_\_ hrs.]
- Industrial/Occupational Health [\_\_\_\_ hrs.]
- Physician Extender [\_\_\_\_ hrs.]
- Other (specify) \_\_\_\_\_ [\_\_\_\_ hrs.]

Indicate the applicant's ability level with an "x" in the grid below:

	Superior 5	Excellent 4	Good 3	Average 2	Below Average 1	Not Observed
Interpersonal Skills						
Communication						
Professionalism						
OVERALL Evaluation						

Name of certified athletic trainer \_\_\_\_\_

Title \_\_\_\_\_

Employer/service location \_\_\_\_\_

Address \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Athletic Training license number and state \_\_\_\_\_

