**APPLICANT FULL NAME (PRINTED)**

**OBSERVATION SITE INFORMATION:**

NAME OF FACILITY/LOCATION:

FACILITY ADDRESS:

SUPERVISOR NAME:

|  |  |  |  |
| --- | --- | --- | --- |
| DATE(MM/DD/YR) | TIME IN – TIME OUT | HOURS COMPLETED | SIGNATURE OF SUPERVISING HEALTHCARE PROVIDER NAMED ABOVE |
|  *10/ 11 /19* |  *8:00am – 11:45am* | *3 hr 45 min* | John Doe, LAT, ATC |
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| **TOTAL HOURS ON THIS PAGE >>>>>** |  |  |

The hours listed on this page are accurate and completed by the applicant listed above.

Applicant Signature Date: