COLLEGE OF APPLIED HEALTH SCIENCES
UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN

Documentation of Clinical/Volunteer Experience

Student Information (to be completed by student)

_____ _____ _____
Last Name First Middle

Address _____ City _____ State_____ Zip _____

Signature of applicant_____ Date _____

Professional's Information (to be completed by professional with whom you are working)

Name _____ License # _____ State _____

Name of facility _____

Address _____

The purpose of this log is to document the applicant's exposure to clinical/volunteer experiences. This form will not be used to assess the applicant's performance in the professional setting or to assess the nature of the professional experience.

Applicant has spent _____ hours at our facility in: [ ] observation [ ] volunteer [ ] employment

Please briefly describe the applicant's experiences at your facility: _____
_____
_____
_____
_____
_____

Signature of professional _____ Date _____