

Clinical Practicum Period **1** **2** **3** **4** : _____
 (Please Circle Appropriate Period) Affiliate Site

Student Name (Please print): _____

**** Minimum of twenty (20) days per rotation, no exceptions ****

	Week #1			Week #2			Week #3			Week #4		
	Date	Arrival TIME	Departure TIME	Date	Arrival TIME	Departure TIME	Site	Arrival TIME	Departure TIME	Date	Arrival TIME	Departure TIME
Mon												
Tues												
Wed												
Thurs												
Fri												

Explanation of **any** absence (dates, excused, unexcused, who student contacted, etc.) – DOCUMENT BELOW:

Student Signature: _____

Instructor Signature: _____

Student is responsible for returning *this original signed copy* of the completed Senior Clinical Practicum Attendance Record to the University of Delaware instructor *within one work week* of the completed practicum period.