NUNM
Record of Clinical Experience

Name: _____ Mailcode: _____

Program: _____ Term/Year: _____

Supervisor Name: _____ Location: _____

☐ Observation ☐ Internship ☐ Hydro
☐ Primary ☐ Secondary

Date & Time	Week	Total # of Patients	Total Hours	Supervisor's Initials
Totals	Do Not Use This Box			No Signature Needed

_____

Supervisor's Signature Date

Directions
1. Obtain supervisor's signature before turning in form.
2. At the end of the term turn original in to the Registrar (a copy will not be accepted).
3. Make a copy for your records.
4. Please add the total number of hours and patient contacts at the bottom of the page.