

**University of Toledo/Wright State University
Clinical Experience Log**

Course Number / Name :

Student Name: _____

Course Objective:

Faculty Name: _____

Clinical Mentor
Name: _____

- 1.
- 2.
- 3.
- 4.
- 5.

Course Objective	Date	Hours	Clinical Site	Activity	Outcomes/Products

Total Supervised Hours _____

Clinical Mentor _____

Signature/Date: _____

Course Faculty _____

Signature/Date: _____

Student _____

Signature/Date: _____