



Student Clinical Schedule

Student Name	
Cell Phone	
Home Phone	
E-mail address	

Training Program Name	
Training Program Type	
Name of Clinical Site	
Address	
Telephone Number	
Instructor Name	

Clinical Schedule			
Date	Day of Week	Times (ex. 9:00 a.m.-2:00 p.m.)	Total # Hrs. for Day
Total Hours			

I affirm the information on this form to be true and correct to the best of my knowledge.

Student/Nurse Aide Trainee Printed Name: _____

Student/Nurse Aide Trainee Signature: _____ Date: _____

Instructor Printed Name: _____

Instructor Signature: _____ Date: _____

The licensed nurse who signs this form must be a program instructor or the nurse aide employee's nurse supervisor. Proficiency is determined by the satisfactory performance of the skill. Per 310:677, 3-4, Trainees shall not perform services for which they have not been trained and found proficient by the instructor.