# CLINICAL TEACHING TIME RECORD

(To Be Completed by Student and Verified by Cooperating Teacher)

Cooperating Teacher's Name | Student's Name | Student ID #

School/District | Sem/Year | Supervisor's Name

| DATE | START/END TIME | DESCRIPTION OF ACTIVITY MUST INCLUDE ACTIVITY COMPLETED OR A DESCRIPTION OF WHAT WAS OBSERVED | Cooperating TEACHER INITIAL |
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Cooperating Teacher's Signature Verifying Days of Completion _____