Clinical Athletic Training Program
Clinical Experience Agreement

UNIVERSITY OF NORTHERN COLORADO
Athletic Training Program

NAME: _____

Personal Information:

Local Address:

Phone:

Bearmail Address:

Emergency Contact:

Name & Relationship:

Address:

Phone:

In order to ensure the protection of both the Athletic Training Student (ATS) and the patients that they will come in contact with during clinical experiences, the following items must be provided to the Program Director (PD).

- Signed Technical Standards Form
- Completed Health Center Clearance Form
- Proof of current Emergency Cardiac Care certification
- Proof of current approved Student Liability Insurance policy coverage
- Proof of completion of current blood borne pathogen / communicable disease policy education and training
- Completed Clinical Supervision Agreement Form

No engagement in any clinical experiences may begin until all items have been satisfactorily provided and both the student and preceptor are notified by the PD that clinical experiences may commence.

Clinical Experience Agreement:

I have read, understand, and agree to abide by all policies, procedures, and guidelines identified in the current version of the Student Handbook (as posted on the program website). I have provided the PD all requested materials and will not engage in any clinical experience until I have been notified that I am cleared to do so by the PD.

ATS Signature:_____ **Date:**_____

PD Clearance:

The above listed student has satisfactorily provided all requested materials and is cleared to begin clinical education experiences associated with the AT program.

PD Signature:_____ **Date:**_____