Student Name_____Clinical Education Center _____

Semester (check one): 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Date	Pt. ID	Name of Exam/Procedure	Rm. or equip #	Fluoro: Exam Time	D / I	# & reason for repeats	Supervising RT (PRINT PLEASE)	Signature of RT (CRT/permit # for fluoro)