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PEDIATRIC REHABILITATION CLINICAL DOCUMENTATION

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Name of Agency: \_\_\_\_\_

Address : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone number: \_\_\_\_\_

Student's name: \_\_\_\_\_

Date of Clinical Experience: \_\_\_\_\_

Verification that the above student completed four hours of pediatric rehabilitation clinical experience:

Preceptor's Name: \_\_\_\_\_

*(Print)*

Date: \_\_\_\_\_

\_\_\_\_\_  
*(Signature)*

Student's Name: \_\_\_\_\_

*(Print)*

Date: \_\_\_\_\_

\_\_\_\_\_  
*(Signature)*