Birthingway Lactation Program Clinical Training Timesheet

Student Name: _____ **Term/Year:** _____ Page ____ of ____

This signed timesheet must be received and time stamped no later than the Monday following the last day of the academic term.

Date	Time In	Time Out	Total Hours	Direct Hours	Description of Work	Preceptor or Co-Preceptor Initials
		Totals:			**Ratio:**	*Ratio of direct-to-total hours must equal at least 60%*

Supervising Preceptor Signature Date Student Signature Date

Office use only:	Date/Time/Initials:
LPC:	Reg Date: _____ Credits Attempted: _____ Credits Completed: _____ IBCLC Eval:_____ Student Eval: _____ Competencies Updated: _____ LPC/File: _____

Updated 5/16/17 LPC