



Medication Assistant – Certified Clinical Hours

(*Hours must be completed under the supervision of a Registered Nurse.)

Student Name: _____

Date	Start Time	Finish Time	Total Time	RN Daily Initials

RN Clinical Supervisor Verification

RN Printed Name: _____

RN License Number: _____

State of Licensure: _____

I certify that I am a licensed Registered Nurse (RN) in good standing. I further certify that I personally supervised the student listed above and that the clinical hours documented on this form were completed with me and are accurate and complete.

RN Signature: _____ Date: _____