Trainee Name: _____

Supervisor's Name: _____

TRAINEE RADIOGRAPHER PROGRESS REPORT No. _____

Date of This Report:	Dates Covered By This Report:

If additional room is needed, use reverse side of this form and/or additional pages

Course of Study Progress Report
Modules Successfully Completed this Period:

Required Procedures Progress Report	
Category 1:	Number of Procedures Performed This Period:
Category 2 (if applicable):	Number of Procedures Performed This Period:

Trainee's Report (to be completed by Trainee)
Trainee's brief analysis of learning experiences including new skills acquired, observations made, insights gained and progress made since last report:
Trainee's statement of any concerns or problems that arose during the course of study or clinical training:

Trainee Name: _____

Supervisor's Name: _____

Report Number: _____

Supervisor's Report (to be filled in by supervisor)
Trainee's Knowledge and Progress made with the Course of Study ❒ N/A during this time period ❒ Meets level of expectation ❒ Exceeds level of expectation ❒ Below level of expectation Comments (include overall assessment and progress made since last report):
Trainee's performance with patients (or simulated positioning):
❒ N/A during this time period ❒ Meets level of expectation ❒ Exceeds level of expectation ❒ Below level of expectation
Comments (include overall assessment and progress made since last report):
Trainee's adherence to health and safety policies and procedures:
❒ N/A during this time period ❒ Meets level of expectation ❒ Exceeds level of expectation ❒ Below level of expectation
Comments:

I certify, to the best of my knowledge, that the information presented is true and accurate.

_____ _____

TRAINEE DATE

_____ _____

SUPERVISOR DATE

This form must be completed and submitted to the Board by mail by the tenth of each month during the traineeship. Failure to timely submit one (1) or more reports or failure to promptly address deficiencies or concerns may result in the immediate termination of the traineeship.

Clinical Training Program

Trainee Name: ____________________________

Supervisor's Name: ____________________________

Category #1: ____________________________

(use separate log for each category)

TRAINEE LOG OF PROCEDURES

Radiologic Procedure Anatomical Area	Date Completed	Type (check one)	Competence Verified by
		☐ Patient ☐ Simulated	Name: License Number:
		☐ Patient ☐ Simulated	Name: License Number:
		☐ Patient ☐ Simulated	Name: License Number:
		☐ Patient ☐ Simulated	Name: License Number:
		☐ Patient ☐ Simulated	Name: License Number:
		☐ Patient ☐ Simulated	Name: License Number:
		☐ Patient ☐ Simulated	Name: License Number:
		☐ Patient ☐ Simulated	Name: License Number:
		☐ Patient ☐ Simulated	Name: License Number:
		☐ Patient ☐ Simulated	Name: License Number:

(Photocopy as needed)

Trainee Name: ____________________________

Supervisor's Name: ____________________________

Category #2: ____________________________
(use separate log for each category)

TRAINEE LOG OF PROCEDURES

Radiologic Procedure **Anatomical Area**	**Date Completed**	**Type (check one)**	**Competence Verified by**
		☐ Patient ☐ Simulated	Name: License Number:
		☐ Patient ☐ Simulated	Name: License Number:
		☐ Patient ☐ Simulated	Name: License Number:
		☐ Patient ☐ Simulated	Name: License Number:
		☐ Patient ☐ Simulated	Name: License Number:
		☐ Patient ☐ Simulated	Name: License Number:
		☐ Patient ☐ Simulated	Name: License Number:
		☐ Patient ☐ Simulated	Name: License Number:
		☐ Patient ☐ Simulated	Name: License Number:
		☐ Patient ☐ Simulated	Name: License Number:

(Photocopy as needed)

Trainee Name: _____

Supervisor's Name: _____

SUMMARY OF PROCEDURES

Please note that the totals on this page must be substantiated on the Training Log(s) accompanying this form.

Radiologic Procedure		**Total Procedures Completed**		
Category	**Anatomical Area**	**Patient**	**Simulated**	**Total**