

School of Diagnostic Imaging  
Cleveland Clinic Health System

**Attendance Verification Form**

Student Name: \_\_\_\_\_

Date to be verified : \_\_\_\_\_

Start time: \_\_\_\_\_(am / pm)

Clinical Instructor/Supervisor Signature :

End time : \_\_\_\_\_(am / pm)

Clinical Instructor/Supervisor Signature :

Today's Date : \_\_\_\_\_

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