STATE OF MAINE
DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION
OFFICE OF PROFESSIONAL & OCCUPATIONAL REGULATION
RADIOLOGIC TECHNOLOGY BOARD OF EXAMINERS
76 NORTHERN AVENUE
GARDINER, MAINE 04345

Janet T. Mills
Governor

Joan F. Cohen
Commissioner

TRAINEE PROGRESS REPORT FORM

Trainees must submit a complete progress report to the Board every 30 days of licensure. Failure to submit timely reports or to promptly address deficiencies or concerns may result in the immediate termination of the traineeship. Trainees and supervisors must notify the Board of any changes in supervision.

Trainee Information	Supervisor Information
Name:	Name:
License Number:	License Number:
Progress Report Period	
Start Date:	End Date:
Course of Study Progress During Report Period	
Completed Module Name(s):	
Clinical Training Progress	
Selected Training Categories: ☐ Skull ☐ Spine ☐ Chest ☐ Extremities ☐ Podiatry	

Summary of Procedures During Report Period
(Data must be validated with accompanying Procedure Logs)

Category & Anatomical Area	Patient	Simulated	Total

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Trainee's Report *(To be completed by Trainee)*
Summary of learning experiences during this reporting period including: new skills acquired, observations made, insights gained and progress made:
Any concerns or problems with the course of study or clinical training during this reporting period:
Supervisor's Report *(To be completed by Supervisor)*
Trainee's course of study knowledge and progress during this reporting period: ☐ N/A ☐ Below Expectation ☐ Meets Expectation ☐ Exceeds Expectation Summary:
Trainee's performance with patients and simulated positioning during this reporting period: ☐ N/A ☐ Below Expectation ☐ Meets Expectation ☐ Exceeds Expectation Summary:
Trainee's adherence to health and safety polices and procedures during this reporting period: ☐ N/A ☐ Below Expectation ☐ Meets Expectation ☐ Exceeds Expectation Summary:
I attest that the information provided on this form is verifiable, factual, and accurate to the best of my knowledge.

Supervisor Signature:	Date:
Trainee Signature:	Date:

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Procedure Log

(A separate form is needed for each verifying supervisor)

Trainee Information		Verifying Supervisor Information	
Name:		Name:	
License Number:		License Number:	
Category & Anatomical Area	**Type**	**Date**	**Verifying Supervisor Initials**
	☐ Patient ☐ Simulated		
	☐ Patient ☐ Simulated		
	☐ Patient ☐ Simulated		
	☐ Patient ☐ Simulated		
	☐ Patient ☐ Simulated		
	☐ Patient ☐ Simulated		
	☐ Patient ☐ Simulated		
	☐ Patient ☐ Simulated		
	☐ Patient ☐ Simulated		
	☐ Patient ☐ Simulated		
	☐ Patient ☐ Simulated		
	☐ Patient ☐ Simulated		
I attest that the information provided on this form is verifiable, factual, and accurate to the best of my knowledge.			
Verifying Supervisor Signature:		Date:	
Trainee Signature:		Date:	