



Department of Physical Therapy
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Doctor of Physical Therapy Program Documentation of Physical Therapy Clinical Observation Hours

Program applicant: Provide form for each physical therapy
 clinical facility in which you have observed and/or are employed.
 Include this form with your program application.

This is to verify that _____

APPLICANT'S NAME, PLEASE PRINT

has observed a licensed physical therapist in the practice setting as noted

Facility name _____

Address _____

Phone _____ Email _____

Name(s) of physical therapist(s) observed _____

Indicate practice setting *and* specialty area where you observed (check all that apply):

- Practice setting
- Inpatient / hospital setting
 - Acute care
 - Inpatient rehabilitation
 - Outpatient clinic / private practice
 - Nursing home / skilled care
 - School system
 - Industrial medicine / work fitness
 - Home health care
 - Wellness / fitness center
 - Other (specify) _____

- Specialty area
- Orthopedic
 - General medical / surgical
 - Neurological
 - Cardiopulmonary
 - Sports medicine
 - Pediatrics
 - Geriatrics
 - Wounds / skin
 - Women's health
 - Aquatic
 - Other (specify) _____

Total hours as a volunteer observer _____

During the period of (mo/yr) _____

Total hours as a paid employee _____

During the period of (mo/yr) _____

I verify that the above information is accurate.

Therapist's supervisor signature _____ Date _____

Student signature _____ Date _____