



# Physical Therapy Observation Hours

## VERIFICATION FORM: Extra

**Form is only intended for use by individuals who need a PT signature for a future admissions cycle**

Some programs require a licensed physical therapist (PT) to verify your physical therapy experiences. If required, select the PT who supervised you during each experience and can best verify your hours. Type or neatly handwrite your information directly onto this form. Leave the PTCAS ID number blank. Deliver the form to the appropriate PT for signature. Once you are ready to apply via PTCAS, you MUST key enter all of your PT experiences on the PTCAS web application exactly as they appear on this signed form. Select the "paper" verification type. Print and attach the new (bar-coded) PTCAS verification form to this "old" signed form. The PT does not need to sign the new PTCAS form, if there are no changes. Send both forms to PTCAS in a single envelope. NOTE: ***If there are any changes to your PT experience after this form is signed, a PT must sign a new form to verify your revised hours.***

Name of Applicant: \_\_\_\_\_ PTCAS ID#: \_\_\_\_\_

Name of Facility: \_\_\_\_\_

Street Address for Facility: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_ \_\_ Zip/ Postal Code: \_\_\_\_\_

Country: \_\_\_\_\_

Name of Physical Therapist: \_\_\_\_\_

PT License Number: \_\_\_\_\_ State of PT License: \_\_\_ \_\_

*Instructions to physical therapist: You must enter your PT licensure information above.*

PT Email: \_\_\_\_\_ PT Phone #: \_\_\_\_\_

Applicant also requested PT to submit reference?  Yes  No

Type of Experience:  Inpatient  Outpatient //  Paid  Volunteer  Both

### PT Settings:

- Acute Care
- Rehab/Sub Acute Rehab
- Extended Care Facility /Nursing Home/Skilled Nursing Facility
- Other (describe): \_\_\_\_\_
- Outpatient Clinic (Private Practice)
- School/Pre-school
- Wellness/Prevention/Fitness
- Industrial/Occupational Health

### Physical Therapy Specialty Area(s) Observed and Hours of Experience in Each Area:

- Cardiovascular & Pulmonary Hrs: \_\_\_\_\_
- Clinical Electrophysiology Hrs: \_\_\_\_\_
- Geriatrics Hrs: \_\_\_\_\_
- Neurology Hrs: \_\_\_\_\_
- Other (describe): \_\_\_\_\_ Hrs: \_\_\_\_\_
- Orthopaedics Hrs: \_\_\_\_\_
- Pediatrics Hrs: \_\_\_\_\_
- Sports Hrs: \_\_\_\_\_
- Women's Health Hrs: \_\_\_\_\_

Total # of Hours Over Span of Experience: \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PHYSICAL THERAPIST

\_\_\_\_\_  
DATE