



Physical Therapy Observation Hours

VERIFICATION FORM

Name of Applicant: _____ PTCAS ID#: _____

Name of Facility: _____

Street Address for Facility: _____

City: _____ State: ____ Zip/ Postal Code: _____

Country: _____ Name of PT: _____

PT License Number: _____ State of PT License: ____

Instructions to physical therapist: Please enter your licensure information above.

PT Email: _____ PT Phone #: _____

Type of Experience: ☐ Inpatient ☐ Outpatient // ☐ Paid ☐ Volunteer ☐ Both

PT Settings:

- | | |
|--|---|
| <input type="checkbox"/> Acute Care | <input type="checkbox"/> School/Pre-school |
| <input type="checkbox"/> Private Practice | <input type="checkbox"/> Federal/State/County Health |
| <input type="checkbox"/> Ambulatory Care | <input type="checkbox"/> Wellness/Prevention/Fitness |
| <input type="checkbox"/> Rehab/Sub-Acute Rehab | <input type="checkbox"/> Industrial/Occupational Health |
| <input type="checkbox"/> ECF/Nursing Home/SNF | |
| <input type="checkbox"/> Other (describe): _____ | |

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

- | | |
|---|--------------|
| <input type="checkbox"/> Cardiovascular & Pulmonary | Hours: _____ |
| <input type="checkbox"/> Clinical Electrophysiology | Hours: _____ |
| <input type="checkbox"/> Geriatrics | Hours: _____ |
| <input type="checkbox"/> Neurology | Hours: _____ |
| <input type="checkbox"/> Orthopaedics | Hours: _____ |
| <input type="checkbox"/> Pediatrics | Hours: _____ |
| <input type="checkbox"/> Sports | Hours: _____ |
| <input type="checkbox"/> Women's Health | Hours: _____ |
| <input type="checkbox"/> Other (describe): _____ | Hours: _____ |

Total Number of Hours Over Span of Experience: _____ Start Date: _____

End Date: _____

SIGNATURE OF PHYSICAL THERAPIST

DATE