



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 PT to verify your physical therapy experiences. If required, provide this completed form to the appropriate PT for signature. Type or neatly handwrite your information directly onto this form, leaving your PTCAS ID number blank. Once you are ready to apply via PTCAS, enter all of your PT experiences on the PTCAS application exactly as they appear on this signed form. Select "paper" verification type. Print and attach the new (bar-coded) PTCAS verification form to this signed form. The PT does not need to sign the new form, if no changes. Send both forms in a single envelope to PTCAS. 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: ____ PT Phone #: _____

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

PT Email: _____ PT Will Also Submit a Reference? Yes No

Type of Experience: Paid Volunteer Both Start Date: _____ End Date: _____

PT Settings and Hours of Experience: Check and enter hours for all settings that apply to applicant's experience in this facility.

INPATIENT Settings: Facility generally admits patients overnight	Hours Completed	Hours Planned / In-progress
<input type="checkbox"/> Acute Care Hospital		
<input type="checkbox"/> Rehabilitation/Sub-acute Rehabilitation		
<input type="checkbox"/> Nursing Home/Skilled Nursing Facility/ Extended Care Facility		
<input type="checkbox"/> Other Inpatient Facility		
OUTPATIENT Settings: Facility has no overnight patients	Hours Completed	Hours Planned / In-progress
<input type="checkbox"/> Free-standing PT or Hospital Clinic		
<input type="checkbox"/> School/Pre-school		
<input type="checkbox"/> Wellness/Prevention/Fitness		
<input type="checkbox"/> Industrial/Occupational Health		
<input type="checkbox"/> Home Health		
<input type="checkbox"/> Other Outpatient Facility		
TOTAL # OF HOURS COMPLETED FOR ALL SETTING		

PT Patient Diagnoses/Populations Observed: Check all below that apply to the applicant's experience at this facility. If the applicant did not directly observe a PT with a particular patient population, do **not** check box, regardless of whether the facility provides related services.

- General Orthopedic (musculoskeletal)
- Neurologic (neuromuscular)
- Cardiovascular / Pulmonary
- Integumentary (wound management)
- Geriatrics
- Pediatrics
- Sports
- Aquatics
- Women's Health
- Other

Taking into consideration these characteristics, how do you think this person would perform as a health care provider?

- I highly recommend this applicant as a health care provider.
- I recommend this applicant as a health care provider.
- I recommend this applicant as a health care provider, but with some reservations.
- I am not able to recommend this applicant as a health care provider.
- I do not have sufficient information about the applicant to respond to this question.

Signature of Physical Therapist

Date