PHYSICAL THERAPIST ASSISTING PROGRAM

EXPERIENCE VERIFICATION FORM

All Applicants Must Submit This Form

Name_____ S#_____ Date:_____

I have completed a TOTAL of _____volunteer/observation hours as verified below. If my total hours are less than 40, I will also submit the observation paper with my application: YES / NO *(circle one)*

Applicants to the PHYSICAL THERAPIST ASSISTING PROGRAM at Cuyahoga Community College are required to obtain 40 hours of documented volunteer, observation, or work experience in a physical therapy environment, under the supervision of a physical therapist or physical therapist assistant, in order to gain familiarity with the attributes, skills and daily tasks required of professionals in the field of physical therapy. The following requirements must be met:

1. Students must complete the 40 hours within 2 years prior to submitting their application to the program.
2. Students must split the 40 hours between at least 2 different types of physical therapy environments, with a minimum of 10 hours at each facility. *(Types: SNF, Out Pt, School, Acute, Rehab, Other)*
3. Students must scan and submit a business card or other printed media from each facility.
4. Students who apply before completing all 40 hours will be asked to complete hours before starting the program.

This form may be used for up to 2 different facilities. Use additional forms as needed

1 - EXPERIENCE VERIFICATION: *Supervising clinician must fill out this box completely*

The student above has volunteered, observed or been employed in the physical therapy department at this facility for a total of _____ hours from _____/_____/_____ to _____/_____/_____.

Name of Facility_____Type_____

Address_____

City_____State_____ Zip_____

Phone _____ Email_____

Printed name of PT/PTA and license #_____

Signature_____Date_____

2 - EXPERIENCE VERIFICATION: *Supervising clinician must fill out this box completely*

The student above has volunteered, observed or been employed in the physical therapy department at this facility for a total of _____ hours from _____/_____/_____ to _____/_____/_____.

Name of Facility_____Type_____

Address_____

City_____State_____ Zip_____

Phone _____ Email_____

Printed name of PT/PTA and license #_____

Signature_____Date_____