

## Physical Therapy Observation Hours Verification Form

A licensed Physical Therapist is required to verify your physical therapy observation experiences. Type or neatly handwrite the below information directly onto this form. Please complete a separate observation form for each facility where you completed observation hours. Once completed please scan and email the form to [b.maclennan@wingate.edu](mailto:b.maclennan@wingate.edu).

**NOTE: *If there are changes to your PT experience after this form has been signed and submitted, a PT must sign a new form to verify your revised hours and you will need to submit this update to [b.maclennan@wingate.edu](mailto:b.maclennan@wingate.edu).***

Name of Applicant: \_\_\_\_\_

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

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

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

PT Email: \_\_\_\_\_

See next page for documenting hours.

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 your experience at this facility.

INPATIENT Settings: Facilities where patients are generally admitted overnight	Hours completed	Hours planned/In-progress
Acute Care Hospital		
Rehabilitation/Sub-acute Rehabilitation		
Nursing Home/Skilled Nursing Facility/Extended Care Facility		
Other Inpatient Facility: _____		
OUTPATIENT Settings: Facility has no overnight patients	Hours completed	Hours planned/In-progress
Free standing PT or Hospital Clinic		
School/Pre-school		
Wellness/Prevention/Fitness		
Industrial/Occupational Health		
Home Health		
Other Outpatient Facility: _____		
TOTAL # OF HOURS COMPLETED AT THIS FACILITY		

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

- |   |  |
|---|--|
| <input type="checkbox"/> General Orthopedic (musculoskeletal) | <input type="checkbox"/> Pediatrics    |
| <input type="checkbox"/> Neurological                         | <input type="checkbox"/> Sports        |
| <input type="checkbox"/> Cardiovascular/Pulmonary             | <input type="checkbox"/> Aquatics      |
| <input type="checkbox"/> Integument (wound care)              | <input type="checkbox"/> Pelvic Health |
| <input type="checkbox"/> Geriatrics                           | <input type="checkbox"/> Other: _____  |

\_\_\_\_\_  
Signature of Physical Therapist

\_\_\_\_\_  
Date