FAULKNER
DEPARTMENT OF PHYSICAL THERAPY

Physical Therapy Observation Hours
Verification Form
Faulkner University DPT Program

Please complete this form for EACH FACILITY in which your physical therapy experiences occurred. Select the licensed physical therapist who supervised you during each experience and can best verify your hours. Applicants must complete the entire form and submit forms directly to the university. Applicants who do not meet the minimum requirements for observation hours will not be considered for admission. Please see Program website for the most up to date information.

Name of Applicant:_____ DOB: _____

Name of Facility: _____

Street Address of Facility: _____

City:_____ State:_____ Zip/ Postal code: _____

Country:_____ telephone number :_____

Name of Physical Therapist: _____

PT license number: _____ **State of License:** _____ **PT email:**_____

Type of Experience: ____ Inpatient ____Outpatient _____ Paid _____ Volunteer _____ Both

PT settings:

_____Acute care _____School/ Pre- school

_____Rehab/ subacute rehab _____Wellness/ Prevention/ Fitness

_____Extended care Facility / Nursing home/ skilled nursing facility _____ Industrial/ Occupational Health

_____Outpatient clinic (private practice)

_____ Other (describe): _____

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

____Cardiovascular and Pulmonary	Hours:_____	____Orthopedics	Hours:_____
____Clinical Electrophysiology	Hours:_____	____Pediatrics	Hours:_____
____Geriatrics	Hours:_____	____Sports	Hours:_____
____Neurology	Hours:_____	____Women's Health	Hours:_____

Total number of hours over the entire experience at this facility: _____

Start Date:_____ **End Date**: _____

_____ _____

(Signature of Physical Therapist) Date