FAULKNER
DEPARTMENT OF PHYSICAL THERAPY

Physical Therapy Observation Hours

VERIFICATION FORM

Please email completed form to CHSadmissions@faulkner.edu

Name of Applicant: _____

Facility Name: _____ City: _____

Facility Address: _____ ___ _____ _____

State: _____ Zip/ Postal Code: _____Country: _____

Name of Physical Therapist: _____

PT License Number: _____State of PT License: _____

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

PT Email: _____

PT Phone #:_____

Type of Experience: ___ Inpatient ___ Outpatient ___ Paid ___ Volunteer ___ Both

PT Settings:

___ Acute Care
___ Rehab/Sub Acute Rehab
___ School/Pre-school
___ Extended Care Facility /Nursing Home/Skilled Nursing Facility
___ Industrial/Occupational Health
___ Wellness/Prevention/Fitness
___Outpatient Clinic (Private Practice)

Other (describe): _____

Observed Hours in each Physical Therapy Specialty area:

Cardiovascular & Pulmonary	Hrs: _____	Clinical Electrophysiology	Hrs: _____
Geriatrics	Hrs: _____	Neurology	Hrs: _____
Women's Health	Hrs: _____	Orthopaedics	Hrs: _____
Pediatric	Hrs: _____	Sports	Hrs: _____

Other (describe): _____ Hrs: _____

Total # of Hours at this location/experience: _____

Start Date: _____ End Date: _____

I verify the hours listed above:

_____ _____

SIGNATURE OF PHYSICAL THERAPIST DATE