**Faulkner University DPT Program - Physical Therapy Observation Hours - Verification Form**

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