S

**AUBURN UNIVERSITY PHYSICAL THERAPY**

**OBSERVATION HOURS VERIFICATION FORM**

At the time of application, a documented minimum of 100 clincial observation hours within the past two years is required. These hours must occur under the supervision of a U.S. licensed physical therapist. Students mut have observation experience in multiple physical therapy practice settings.

**APPLICANT VERIFICATION** *(to be completed by the applicant)*

**Name of Applicant:**

**Name of Facility:**

**Street Address for Facility:**

**State:**    **Zip/Postal Code:**       **City:**

**Country:**

**Type of Experience:** [ ]  Inpatient [ ]  Outpatient

**Physical Therapy Settings:**

[ ]  Acute Care [ ]  Outpatient Clinic (Private Practice)

[ ]  Sub Acute Rehab [ ]  School, Pre-School

[ ]  Extended Care Facility, Nursing Home, Skilled Nursing Facility [ ]  Wellness, Prevention, Fitness

[ ]  Industrial, Occupational Health

[ ]  Other (describe):

**Physical Therapy Speciality Area(s) Observed and Hours of Experience in Each Area:**

[ ]  Cardiovascular and Pulmonary Hrs:       [ ]  Orthopedics Hrs:

[ ]  Clinical Electrophysiology Hrs:       [ ]  Pediatrics Hrs:

[ ]  Geriatrics Hrs:       [ ]  Sports Hrs:

[ ]  Neurology Hrs:       [ ]  Women’s Health Hrs:

[ ]  Other (describe):

**Total Number of Hours:**       **Start Date:**       **End Date:**

s

**PHYSICAL THERAPIST VERIFICATION** *(to be completed by the supervising physical therapist)*

**Name of Physical Therapist:**

**State of PT License:**    **PT License Number:**

**PT Phone Number:**       **PT Email:**

**Applicant also requested physical therapist to submit a letter of recommendation?** [ ]  Yes [ ]  No

*Please sign below to attest that the information provided above is accurate.*

*Please sign to attest that all information provided on this form is true and accurate to the best of your knowledge.*

   /   /

*DATE*

*PHYSICAL THERAPIST SIGNATURE*