MESSIAH UNIVERSITY

DOCTOR OF PHYSICAL THERAPY PROGRAM

OBSERVATION HOURS

Name of applicant: _____

Name of facility: _____

Street Address for facility: _____

City: _____ State:_____ Zip: _____

Name of physical therapist: _____

PT License Number:_____ State of PT License: _____

PT e-mail: _____ PT phone #: _____

Applicant also requested PT to submit reference? ☐ Yes ☐ No

Type of experience: ☐Inpatient ☐Outpatient // ☐Paid ☐Volunteer ☐Both

PT Settings:

☐Acute care
☐Rehab/Sub-acute rehab
☐Extended care facility/nursing home/skilled nursing facility
☐Other_____
☐Outpatient clinic (private practice)
☐School/pre-school
☐Wellness/prevention/fitness
☐Industrial/occupational health

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

☐Cardiovascular & Pulmonary	Hrs:	☐Orthopedics	Hrs:
☐Clinical Electrophysiology	Hrs:	☐Pediatrics	Hrs:
☐Geriatrics	Hrs:	☐Sports	Hrs:
☐Neurology	Hrs:	☐Women's Health	Hrs:
☐Other (describe) _____			Hrs:

Total # of hours over span of experience: _____

Start date: _____ End Date:_____

_____ _____

SIGNATURE OF PHYSICAL THERAPIST **DATE**