Physical Therapist Assistant Program Observation Hours Verification Form

Applicant Name: _____ **Facility Name/Location:** _____

Settings/Patient Types (Circle All That Apply)

Acute Care	Outpatient Clinic	Sports Medicine	Industrial Medicine
Rehab Facility	School System	Home Health	Hospice
Skilled Nursing Facility	Wellness Center	Government Agency	Research Center

Date	Time In	Time Out	Total Observation Time (Minus non-patient time)	Staff Signature/License #
Page Total of Actual Hours				