



PHYSICAL THERAPIST ASSISTANT CLINICAL EXPERIENCE DOCUMENTATION

TO BE FILLED OUT BY APPLICANT AND FORWARDED TO PT CLINIC SUPERVISOR—PLEASE PRINT NEATLY

Applicant's Full Name: _____
first middle last

Address: _____
street address city state zip code

Telephone: _____ Email: _____

Please read the following admissions policy and sign below.

I understand that PTA applicants are required to have a minimum of 50 hours of documented PT clinical observation experience. It is preferred that clinical experiences be obtained from two different clinical sites. Applicants currently employed in PT clinical settings may use their place of employment as one of the two settings.

Signature: _____ Date: _____

Applicant's, please ensure the document is filled out in its entirety before uploading it to your online application. The online application for the Fall program may be found between February 15 and May 15 at www.howardcc.elluciancrmrecruit.com/Apply/Account/Login

PHYSICAL THERAPY CLINIC SUPERVISOR

PTA applicants must complete a minimum of 50 documented hours of clinical experience in which they can learn more about the PT field. We appreciate your assistance in completing this form which will become part of the applicant's admissions package. For questions, please contact HCC's Admissions Team at admissions@howardcc.edu

PHYSICAL THERAPY CLINIC SUPERVISOR—PLEASE COMPLETE AND SIGN

Facility Name: _____ Telephone: _____

Facility Address: _____
street address city state zip code

Dates of Experience: _____ Number of Hours Spent in Clinic: _____

The primary type of involvement the applicant had in the clinic was as: (select one)

☐ Volunteer ☐ Paid employee ☐ Patient ☐ Observer of a friend/family member who was a patient ☐ Other

If other, please describe: _____

The type of experience the applicant had in the clinic included: (select all that apply)

☐ Observation only ☐ Observation and conversation with patients/staff
☐ Some hands-on experience with patient ☐ Frequent assistance with treatment under staff supervision
☐ Some patient transport duties ☐ Occasional assistance with equipment and monitoring of independent treatment activities

If other, please describe: _____

This facility can best be described as:

☐ Inpatient rehabilitation setting ☐ Outpatient orthopedic setting ☐ Outpatient rehabilitation setting

If other, please describe: _____

Supervisor's Name: _____ Title: _____

Signature: _____ Date: _____