

## Verification of Physical Therapy Clinical Observation Form

Applicant's Name \_\_\_\_\_

To better prepare you for entry into the Doctor of Physical Therapy program at DeSales University, you are required to complete observation time with a licensed physical therapist. The following information will guide you in planning your observation experiences to satisfy this application prerequisite.

### Observation Requirements:

- Documentation of a minimum of 40 observation/volunteer/internship/employment hours at a single physical therapy facility
- Additional observation hours in a variety of physical therapy practice settings is **highly recommended** (i.e. acute care, inpatient rehabilitation, outpatient rehabilitation, geriatrics, pediatrics, home health care, sports medicine)
- All observation hours must be completed **no more than two years** prior to application submission
- Completion of one verification form for each facility or institution (this form may be photocopied)
- **This form is NOT VALID without a licensed physical therapist's signature**

Prospective Student Response: During this experience I observed / performed the following patient-related activities:

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### Facility Information:

Facility Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
*Street City State Zip Code*

Practice setting: ☐ Acute Care / Hospital ☐ Inpatient Rehabilitation ☐ Geriatrics  
☐ Outpatient Rehabilitation ☐ Home Health Care ☐ Pediatrics  
☐ Sports Medicine ☐ Other \_\_\_\_\_

Dates of Observation: From \_\_\_\_ / \_\_\_\_ / 20\_\_\_\_ to \_\_\_\_ / \_\_\_\_ / 20\_\_\_\_

Total observational hours under the supervision of a licensed physical therapist at this site: \_\_\_\_\_

**Supervising Therapist Responses:** Your assistance in providing an objective evaluation of the candidate's character and ability to undertake an intense academic program of graduate studies in physical therapy is appreciated. **After completing the following sections of this document and verifying the facility and observation information above, please sign, date and mail to the address indicated in the upper right hand corner of this page. If submitting in printed format, please enclose in envelope, seal and include signature across flap.** Thank you for your cooperation.

1. Please indicate how long and in what capacity you have known the applicant. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Using the grid below, please evaluate the applicant in comparison to others you have known in the same capacity.

	<b>Exceptional</b>	<b>Very Good</b>	<b>Good</b>	<b>Average</b>	<b>Below Average</b>	<b>Unable to Evaluate</b>
Intellectual Ability						
Personal Maturity						
Interpersonal Skills						
Written Communication Skills						
Oral Communication Skills						
Initiative/Motivation						
Professionalism						
Adaptability/Flexibility						
Time Management						
Overall Potential for Graduate Study						

3. In the space provided, please include any additional information that you would like the Doctor of Physical Therapy Program Admissions Review Committee to consider regarding this applicant.

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Please indicate if you would recommend this applicant to enter a doctor of physical therapy education program based on your observations:

☐ Recommend without reservation      ☐ Recommend with reservations      ☐ Would not recommend

Comments 

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By signing this form, I hereby verify that the information on this form is true and accurate.

\_\_\_\_\_  
Supervising Physical Therapist Signature

\_\_\_\_\_  
Date Signed

E-mail Address: \_\_\_\_\_

\_\_\_\_\_  
PT License # \_\_\_\_\_ Issuing State \_\_\_\_\_  
Printed Name and Physical Therapist License Information of Supervising Physical Therapist