Physical Therapist Assistant Program
Clinical Experience Documentation Form

(Print a separate form for each facility)

Name of Applicant ______________________

WSCC Student #: A______________________

Facility Name: ______________________

Facility Address: ______________________

City: ______________ State: ________

Phone: ______________________

The PTA program requires that applicants complete a minimum of 24 quality hours in at least two (2) completely different Physical Therapy Departments. Additional hours beyond the minimum (and up to a maximum of 100 hours) will improve the application score and are recommended. Quality hours are defined as actual time spent observing physical therapy patient care, not time spent observing department "down time". Credit should not be given for anything outside of physical therapy patient care activities (i.e., lunch, secretarial duties, videos, time spent with occupational therapy, etc.) Full days that do not include a lunch break will automatically be deducted one (1) hour. Observation must be performed under a licensed Physical Therapist or Physical Therapist Assistant. Time spent observing with an OT/OTA will not count and time spent with a PT/OT team cannot be counted on both the PTA and OTA program applications.

Do not use this form to document hours worked as a physical therapy aide. For hours worked as a physical therapy aide have your supervising PT/PTA write a letter on company letterhead documenting starting date, ending date and total hours worked.

	DATE	STARTING TIME HR MIN AM/PM	ENDING TIME HR MIN AM/PM	# of Hours (Rounded to the nearest quarter hour)
1	/ /	:	:	
2.	/ /	:	:	
3.	/ /	:	:	
4.	/ /	:	:	
5.	/ /	:	:	
6.	/ /	:	:	
7.	/ /	:	:	
8.	/ /	:	:	
9.	/ /	:	:	
10.	/ /	:	:	
11.	/ /	:	:	
12.	/ /	:	:	
13.	/ /	:	:	
14.	/ /	:	:	
15.	/ /	:	:	
16.	/ /	:	:	
17.	/ /	:	:	
18.	/ /	:	:	
19.	/ /	:	:	
20.	/ /	:	:	
		TOTAL DAYS (This Page)	TOTAL HOURS (This Page)	

I certify that the hours listed above were performed by me in physical therapy. I also certify that these are physical therapy (not occupational therapy) hours and are not being duplicated for any other WSCC health program application. I understand that these hours may be verified for authenticity and realize that falsification of this document will result in my application to the PTA Program being withdrawn from consideration.

Student Signature ______________________ Date ______________

I certify that the hours listed above were spent under my supervision or the supervision of one of my licensed physical therapy coworkers and involve the observation of direct physical therapy patient care. **If this sheet is not completely filled in, I have placed my initials beside the final hour(s) completed.**

Supervising Therapist Signature ______________________ License # ______________ Date ______________