

A minimum of one-hundred (100) hours of observation in a physical therapy facility (within the United States) under the supervision of a licensed physical therapist is required as part of the prerequisites for admission to the Fresno State Master of Physical Therapy-Doctorate of Physical Therapy (MPT-DPT) program; fifty (50) hours of which MUST be in a general acute care/inpatient setting.

Instructions: It is **required** that a licensed physical therapist (PT) **verify** your physical therapy observation hours. Ask the PT who supervised you during each experience to verify your hours by completing this form. Keep this form after verification. When you are ready to apply via our online application service, Physical Therapist Centralized Application Service (PTCAS), you will need to enter all of your physical therapy observation hours on the PTCAS web application and must attach the bar-coded PTCAS verification form for that cycle to this signed form; then mail both forms to PTCAS. The bar-coded PTCAS verification form does not need to be verified again if this form has previously been verified. Send only one signed form per physical therapy observation experience.

Mail this form to: PTCAS – Verification of PT Hours Form, P.O. Box 9112, Watertown, MA 02471

THIS SECTION TO BE COMPLETED BY THE APPLICANT

Name of Applicant: _____ Applying for MPT-DPT entry in Fall _____
Year

I understand this verification form is to be received and maintained in confidence by Fresno State for admission to the Physical Therapy program. I hereby expressly waive any and all rights I might have to access this form under the Family Rights and Privacy Act of 1977, and any or all other laws, regulations or policies. I understand that the rights I am waiving include, but are not limited to the right to inspect and review this form, the right to have a copy of this form made for my use, and the right to request an amendment to this form.

_____ I agree to waive access to this form.

_____ I do not agree to waive access to this form.

Signature

Date

THIS SECTION TO BE COMPLETED BY THE PHYSICAL THERAPIST

Instructions to physical therapist: Confidential information. Please place in sealed envelope after verification.

Name of Facility: _____

Street Address for Facility: _____

City: _____ **State:** _____ **Zip/Postal Code:** _____

Name of Physical Therapist: _____

PT License Number: _____ **State of PT License:** ____

Instructions to physical therapist: You must enter your PT licensure information above. This information will be kept confidential.

PT Email: _____ **PT Phone #:** _____

Type of Experience: Inpatient Outpatient Paid Volunteer Both

Physical Therapy Settings:

- | | |
|---|---|
| <input type="checkbox"/> Acute Care | <input type="checkbox"/> Outpatient Clinic (Private Practice) |
| <input type="checkbox"/> Rehab/Sub Acute Rehab | <input type="checkbox"/> School/Pre-School |
| <input type="checkbox"/> Extended Care Facility/Nursing Home/Skilled Nursing Facility | <input type="checkbox"/> Wellness/Prevention/Fitness |
| <input type="checkbox"/> Industrial/Occupational Health | <input type="checkbox"/> Other (describe): _____ |

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Cardiovascular & Pulmonary Hrs: _____ | <input type="checkbox"/> Neurology Hrs: _____ | <input type="checkbox"/> Sports Hrs: _____ |
| <input type="checkbox"/> Clinical Electrophysiology Hrs: _____ | <input type="checkbox"/> Orthopaedics Hrs: _____ | <input type="checkbox"/> Women's Health Hrs: _____ |
| <input type="checkbox"/> Geriatrics Hrs: _____ | <input type="checkbox"/> Pediatrics Hrs: _____ | |
| <input type="checkbox"/> Other (describe): _____ | | Hrs: _____ |

Total # of Hours Over Span of Experience: _____

Start Date: _____

End Date: _____

SIGNATURE OF PHYSICAL THERAPIST

DATE