FRESNO STATE
Physical Therapy

Physical Therapy Observation Hours
VERIFICATION FORM

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 Doctor of Physical Therapy (DPT) program; twenty (20) 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:

☐ Acute Care
☐ Rehab/Sub Acute Rehab
☐ Extended Care Facility/Nursing Home/Skilled Nursing Facility
☐ Industrial/Occupational Health
☐ Outpatient Clinic (Private Practice)
☐ School/Pre-School
☐ Wellness/Prevention/Fitness
☐ Other (describe): ______________________________

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

☐ Cardiovascular & Pulmonary Hrs: ______ ☐ Neurology Hrs: ______ ☐ Sports Hrs: ______
☐ Clinical Electrophysiology Hrs: ______ ☐ Orthopaedics Hrs: ______ ☐ Women's Health Hrs: ______
☐ Geriatrics Hrs: ______ ☐ Pediatrics Hrs: ______
☐ Other (describe): ____ Hrs: ______

Total # of Hours Over Span of Experience: _________

Start Date: ______________________ **End Date:** ______________________

____ ___________________
SIGNATURE OF PHYSICAL THERAPIST *DATE*

Revised 6/25/2013