Physical Therapist Assistant Program
Clinical Experience Documentation Form

(Print a separate form for each facility)

Name of Applicant _____ Facility Name: _____

WSCC Student #: _____ Facility Address: _____

Social Security #: _____ City: _____ State: _____

Phone: _____

The PTA program requires that applicants complete a minimum of 24 quality hours in at least two Physical Therapy Departments. Additional hours beyond the minimum (and up to a maximum of 400 hours) will improve the application score and is recommended. By quality experience we mean 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.) Hours of observation must be performed under a Physical Therapist or Physical Therapist Assistant.

Do not use this form to document hours worked as a physical therapy aide. For hours worked as a physical therapy aide have your employer's human resources office print a physical therapy work history and have that form signed by your supervising PT/PTA, or, your supervising PT/PTA can write a letter on company letterhead documenting total work hours.

	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.	/ /	:	:	
21.	/ /	:	:	
22.	/ /	:	:	
23.	/ /	:	:	
24.	/ /	:	:	

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 the WSCC Admissions Committee may verify this document for authenticity and realize that falsification of this document will result in my application to the PTA Program being withdrawn from consideration.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

Revised: 9/14