Physical Therapist Assistant Program
Clinical Experience Documentation Form

(Print a separate form for each facility)

Name of Applicant _____ Facility Name: _____

WSCC Student #: _____ 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 Companies / Departments. Additional hours beyond the minimum (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.) Hours of observation must be performed under a licensed 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 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 nearest quarter hour). Full days that do not show a lunch break will be deducted 1 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for authenticity and realize that falsification of this document will result in my application to the PTA Program being withdrawn from consideration.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 direct observation of physical therapy patient care. **If this sheet is not completely filled in, I have placed my initials on the line beside the final hour(s) completed.**

_____ _____ _____

Supervising Therapist Signature License # Date

Revised: 9/18