

West Chester University

DOCUMENTATION SHEET

PHYSICAL THERAPY (PT) OBSERVATION HOURS

FOR STUDENTS ENROLLED IN THE B.S. IN EXERCISE SCIENCE PRE-PT CONCENTRATION

PLEASE PRINT:

Student Name: _____

Name of Facility where student observed: _____

Street Address, City, State of Facility _____

Name of Physical Therapist who supervised you during the observation experience and/or can verify your PT observation hours.

PT License Number _____ State of PT License _____

PT Email Address _____ PT Phone Number _____ - _____ - _____

Type of Experience: _____ Inpatient _____ Outpatient experience _____ Observation only

_____ Paid _____ Volunteer Experience

PT Setting (Select all that apply):

_____ Children and Youth _____ Work and Industry _____ Mental Health

_____ Rehabilitation _____ Health and Wellness _____ Productive Aging

_____ Other _____

Start Date _____ End Date _____

Total Number of Hours Over Span of Experience: _____

Signature of PT: _____

Signature of Student: _____