**SAU logoDoctor of Physical Therapy Program**

**Department of Physical Therapy** Documentation of Physical Therapy

**1320 W. Lombard Street**  Clinical Observation Hours

**Davenport, IA 52804**

**563/333-6403**

[**pt@sau.edu**](mailto:pt@sau.edu) **•** [**www.sau.edu/pt**](http://www.sau.edu/pt)

**Please type in form, print, and take to therapist to sign before returning to St. Ambrose University Physical Therapy Department.**

|  |
| --- |
| This is to verify that |
| APPLICANT NAME |

**Has observed a licensed physical therapist in the practice setting as noted.** PTA observation cannot be included.

|  |  |
| --- | --- |
| Facility Name |  |
| Address |  |
| Phone |  |
| E-mail |  |

Name(s) of **physical therapist**(s) observed

**Indicate practice setting and specialty area where you observed (check all that apply):**

**Practice Setting Completed Hours Specialty Area**

|  |  |
| --- | --- |
| Inpatient Setting and Hours | Orthopedic |
| Acute Care: hours = | General medical / surgical |
| Inpatient rehabilitation: hours = | Neurological |
| Nursing home/skilled care: hours = | Cardiopulmonary |
| Other Inpatient: hours = | Wounds / skin |
| Outpatient | Geriatrics |
| Free-standing PT Clinic: hours = | Pediatrics |
| School system: hours = | Sports medicine |
| Wellness/fitness center: hours = | Aquatic |
| Industrial/work fitness: hours = | Women’s health |
| Home health care: hours = | Other (specify): |
| Other Outpatient: hours = |  |
|  |  |

During the dates of:

I verify that the above information is accurate.

**Physical Therapist’s** or Supervisor Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_