



# Post-Grad Clinical Work Experience

## FOR APPLICANT TO COMPLETE BEFORE MAILING TO SCHOOL

LAST NAME	FIRST NAME	MIDDLE NAME

DATE OF BIRTH (MM/DD/YY)	FILE NUMBER

Name of direct supervisor: \_\_\_\_\_

PT, PTA, or Other?: \_\_\_\_\_

Email Address: \_\_\_\_\_

Name of person completing the form (if different from direct supervisor): \_\_\_\_\_

PT, PTA, or Other?: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

Type of facility (hospital, private clinic, etc.) \_\_\_\_\_

Phone Number: \_\_\_\_\_

Website: \_\_\_\_\_

Applicant's dates of employment as a PT: From \_\_\_\_\_ To \_\_\_\_\_

**Average** hours/week worked in direct patient care as a PT: \_\_\_\_\_

**Total** number of hours worked in direct patient care as a PT in the three years immediately prior to submission of this form:

\_\_\_\_\_

List of physical therapists that worked at the facility with the applicant:

Name	Title	Years of experience as a PT

Name	Title	Years of experience as a PT

Name	Title	Years of experience as a PT

Based upon the performance of \_\_\_\_\_, the applicant **has/has not (circle one)** exhibited safe and effective care as a Physical Therapist.  
Name of applicant

To my knowledge, \_\_\_\_\_ **has/has no (circle one)** disciplinary actions or complaints filed within the past three years on any professional license.  
Name of applicant



# Post-Grad Clinical Work Experience

*Attestation of person completing form. Requires notary seal and signature.*

I, \_\_\_\_\_, hereby certify under oath that I am the person who completed  
*Print name*  
form regarding post-graduate clinical work experience for \_\_\_\_\_; and  
*Name of Applicant*  
That all statements and documents enclosed herein are true.

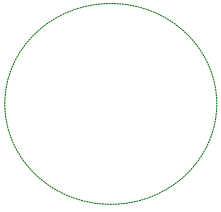
\_\_\_\_\_  
*SIGNATURE*

\_\_\_\_\_  
*DATE*

**NOTARY USE ONLY**

Subscribed and sworn to before me, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, in the  
Country of \_\_\_\_\_, State of \_\_\_\_\_, City of \_\_\_\_\_

\_\_\_\_\_  
*SIGNATURE & SEAL OF NOTARY*



*Attestation of person completing form. Requires notary seal and signature.*

I, \_\_\_\_\_, hereby certify under oath that, to the best of my knowledge,  
*Print Name*  
all statements and documents enclosed herein as part of the post-graduate clinical work experience verification form are true.

\_\_\_\_\_  
*SIGNATURE*

\_\_\_\_\_  
*DATE*

**NOTARY USE ONLY**

Subscribed and sworn to before me, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, in the  
Country of \_\_\_\_\_, State of \_\_\_\_\_, City of \_\_\_\_\_

\_\_\_\_\_  
*SIGNATURE & SEAL OF NOTARY*

