

DOCUMENTATION OF EXPERIENCE FORM

PLEASE PRINT: Part 1 is to be completed by the applicant. Part 2 (back of this page) is to be completed by the Physical Therapist or Physical Therapist Assistant providing the documentation of experience.

NOTE: Therapists who supervise volunteer experiences cannot be a relative or personal friend of the student applicant.

PART I: IMPORTANT!

To the applicant: Complete ONLY Part 1 of this form before sending it with a stamped envelope to the PT or PTA who will be providing documentation of volunteer or work experience. Write the PTA Program's address on the envelope. **DO NOT HAVE THE FORM MAILED BACK TO YOU.**

1. Applicant's name: _____
2. STC Student ID #: A _____
3. Current Address: _____
4. Name of the PT or PTA supplying documentation: _____

- | | name | title | facility |
|--|----------------------|--------------------|----------|
| 5. Dates you spent at the above facility: | _____ | | |
| 6. Total hours you spent at the above facility: | _____ | | |
| 7. Circle the one type that best describes the facility: | | | |
| | Acute care hospital | Rehabilitation | |
| | Long term care | Home health | |
| | School system | Out-patient clinic | |
| | Skilled nursing unit | Other: _____ | |

8. Circle the types of patients/diagnoses you observed:

Orthopedic	Athletic injuries	Neurological (stroke, brain injury)
Spinal cord injury	Pediatrics	Amputees
Wounds/burns	Cardiac conditions	Hand/ Upper extremity
Chronic pain/ pain	General Surgery	other: _____

9. Circle the following that describes the Physical Therapy interventions/activities you observed:

Exercise	Wound/burn care	Critical care/Intensive care
Gait training	Aquatic therapy	Home health program
Family training	Cardiac rehab	Work hardening/conditioning
Sports PT	Pain management	Modalities
Evaluations	Other _____	

9. Please comment on the benefits of Physical Therapy interventions for the patients you observed:

PART 2: TO BE COMPLETED BY THE PHYSICAL THERAPIST/ASSISTANT

IMPORTANT: To the physical therapist/assistant: The person described in Part I of this form is applying for admission to the South Texas College's Physical Therapist Assistant Program and is stating that experience or observation was gained under your supervision.

1. Please summarize this applicant's level of performance by indicating a score for each criteria using the following scale: **Poor, Fair, Good, Exceptional.** Please comment if appropriate.

Listening skills: _____

(attentiveness, responses, active listener)

Comments: _____

Verbalization: _____

(content, verbal interaction, language usage)

Comments: _____

Interest: _____

(questions, level of enthusiasm, overall attentiveness)

Comments: _____

Behavior: _____

(body language, manners, reliability, interaction with patients and staff)

Comments: _____

Initiative: _____

(readily offers assistance, seeks learning opportunities, timeliness/compliance)

Comments: _____

2. Volunteer observer? Yes _____ No _____ Number of Hours _____

Paid employee? Yes _____ No _____ Number of Hours _____

3. _____ I recommend this applicant for admission without reservations.

_____ I recommend this applicant, with reservations. Explain: _____

_____ I do not recommend this applicant. Explain: _____

4. _____ I am not a relative or personal friend of this applicant.

ATTENTION: FORM MUST BE FILLED OUT BY A PHYSICAL THERAPIST OR PHYSICAL THERAPIST ASSISTANT. (We will not accept forms that are filled out by Chiropractors, Athletic Trainers, or Medical Doctors)

Signature Title PT/PTA License # Date

Name (Print) Facility Address Phone

PLEASE RETURN THIS FORM IN THE ADDRESSED STAMPED ENVELOPE (PROVIDED BY THE APPLICANT) BEFORE THE APPLICATION DEADLINE SO THAT THIS APPLICANT MAY BE CONSIDERED FOR THE FALL SEMESTER. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT DIANA HERNANDEZ, PT, M.Ed. AT (956) 872-3152 or (956) 872-3161. THANK YOU FOR YOUR ASSISTANCE

Attention: Physical Therapist & Physical Therapist Assistants

Please fill out this form and mail to the following:

South Texas College

PTA Program Attn.: Diana Hernandez, PT, MEd, Program Chair

P.O. Box 9701, McAllen, TX 78501

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name	title	facility
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14. Dates you spent at the above facility: _____

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16. Circle the one type that best describes the facility:

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17. Circle the types of patients/diagnoses you observed:

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