Clinical Experience Documentation Form

Entry-Level Doctor of Physical Therapy Program

This form is to document the applicant's experiences in a health care environment.
It is not a recommendation form.

Applicant's name____ Carroll ID # (If known)____________________

D.O.B.______________________________

The above individual is applying for admission into the Entry-Level Doctor of Physical Therapy Program at Carroll University, Waukesha, WI. Please complete this clinical experience documentation form, place it in a sealed envelope and return it to the applicant or Carroll University Office of Admission, 100 North East Avenue, Waukesha, WI 53186.

Release of access to document:
The applicant must complete and sign the following before submitting this form to the reference. This request is in compliance with Federal Law P.L. 9380, Family Education Rights and Privacy Act of 1974.

[ ] I waive my right of access to this document.
[ ] I do not waive my right of access to this document.

Applicant's signature ____

The applicant has spent _______ hours in _______ observation; _______ volunteer, or ________employment at my facility. Dates of attendance ____

Briefly describe the clinical setting and the applicant's activities.

Name of licensed physical therapist ____

Title____

Name of facility ____

Address ____

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Signature____ Date__________________

Physical therapy license number and state ____

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