Entry-Level Doctor of Physical Therapy Program
Professional Phase
Clinical Experience Documentation Form

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

APPLICANT SECTION:

Applicant's name (print) _____ **Carroll ID #** (If known)_____

Date of Birth _____ **Email Address** _____

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 _____

LICENSED PHYSICAL THERAPIST SECTION:

The above individual is applying for admission into the Entry-Level Doctor of Physical Therapy Program at Carroll University, Waukesha, WI.

Instructions: Please complete this clinical experience documentation form and return the document to the applicant or to Carroll University Office of Admission 100 North East Avenue, Waukesha, WI 53186. Note: If the applicant selects to waive their right of access please place in a sealed envelope with the licensed PT signature across the seal.

The applicant has spent____hours in [ ] observation; _____hours in [ ] volunteer, and/or _____hours in [ ] employment at my facility.
Total Hours:_____
Dates of Attendance:_____

Indicate the number of hours and practice setting(s) where the applicant observed (check all that apply):

INPATIENT SETTINGS:

- ☐ Acute Care Hospital [____hrs.]
- ☐ Rehabilitation/Sub-acute Rehabilitation [____hrs.]
- ☐ Nursing Home/Extended Care Facility [____hrs.]
- ☐ Other (specify)_____ [____hrs.]

OUTPATIENT SETTINGS:

- ☐ Free-standing PT or Hospital Clinic [____hrs.]
- ☐ School/Pre-school [____hrs.]
- ☐ Industrial/Occupational Health [____hrs.]
- ☐ Home Health [____hrs.]
- ☐ Other (specify)_____ [____hrs.]

Indicate the applicant's ability level with an "x" in the grid below:

	Superior 5	Excellent 4	Good 3	Average 2	Below Average 1	Not Observed
Interpersonal Skills						
Communication						
Professionalism						
OVERALL Evaluation						

Name of licensed physical therapist _____

Title _____

Name of Facility _____

Address _____

Phone (____) _____ Email _____

Signature_____Date _____

Physical therapy license number and state _____