COLLEGE OF GRADUATE STUDIES
ANGELO STATE UNIVERSITY

Physical Therapy Volunteer Hours

(Use one sheet for each facility)

Student Name: _____ CID# : _____

Facility (no abbreviations): _____

Address: _____
City State Zip

Facility Phone: ( ) _____ Fax: ( ) _____

Type of Facility: (Check all areas where you observed at this facility)

- ☐ Hospital
- ☐ Ambulatory Care/Outpatient Center
- ☐ Private Practice
- ☐ Industrial Rehab Center
- ☐ Sports Medicine Clinic
- ☐ Government Agency
- ☐ Charitable Organization
- ☐ ECF/SNF/Nursing Home
- ☐ Home Health
- ☐ School System
- ☐ Other (specify) _____

Patient demographics: ☐ Inpatient ☐ Outpatient

Patient Age Range: ☐ <1 (neonate) ☐ 1-4 (preschool) ☐ 5-12 (school)

Clinical Experiences: (Briefly list the types of programs and the number of hours you specifically observed). Examples: aquatics, critical care/ICU, early intervention, employee intervention, home health, industrial/ergonomic PT, neonatal care, pain clinic, orthopedics, prevention/wellness, pulmonary rehab, research, sport physical therapy, wound care, cardiac rehab, neurological rehab, prosthetics/orthotics, etc.)

OBSERVED	HOURS	DATES	TOTAL HOURS	SUPERVISOR'S INITIALS
Example: Aquatics	2hrs/wk	12/01/98-12/31/98	8 hrs.	

Total number of hours of observation: _____

Student Signature: _____ Date: _____

Physical Therapist's Signature: _____ Date: _____

Please Print Physical Therapist's Information:

_____ _____ _____
Name Title Licensure No.

The information you have supplied on this form is maintained by the University. You have the right to review and correct it by contacting the College of Graduate Studies.

Revised 03/11