PHYSICAL THERAPIST ASSISTANT PROGRAM
OBSERVATION/WORK EVALUATION FORM
2019

Chattahoochee TECHNICAL COLLEGE

Name of Applicant: _____

Name of Facility: _____

Facility Address: _____

_____

Facility Phone: _____

Type of exposure (circle one): Full-time aide / Part-time aide / Volunteer / Observation only

Please indicate the <u>total number of observation hours</u> in the appropriate practice area:

OUTPATIENT (12 hours minimum)

Number of Hours	Facility
	Orthopedic / Sports
	Aquatic / Hippotherapy
	Home Health
	School / Preschool

INPATIENT (12 hours minimum)

Number of Hours	Facility
	Acute care
	Skilled Nursing (SNF) / Sub-acute
	Long Term Acute Care (LTAC)
	Inpatient Rehab (IRU)

PRINTED name of supervising clinician: _____

Title of supervising clinician (PT or PTA): _____

Phone Number: _____

Signature: _____ Date: _____

Please place this form in a sealed envelope with your signature over the seal.
Thank you for assisting our PTA Candidates with their admissions process!

Comments: _____

_____

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