Name of Applicant (Printed): __________________________________________________________

- MUST BE FILLED OUT AND SIGNED BY THE PT CLINIC SUPERVISOR (signature is on page 2 of this form)

1. Dates of clinical experience were from ____________ to ______________
   Month/year month/year

2. The total amount of hours the applicant has spent in my department
   a. 0-25 hours
   b. 26-50 hours
   c. 51 or more hours

3. The applicant was (choose one)
   a. A volunteer
   b. A paid employee (PT Tech or Aide)
   c. An observer of a family or friend who was a patient
   d. A patient

4. The type of experience
   a. Observation only
   b. Some patient duties (i.e. transport, conversation, check in)
   c. Occasional assistance with equipment, monitoring of treatments, patient/client transport/set-up
   d. Frequent assistance with patients/clients under staff direction and supervision

5. This facility can best be described as:
   a. Acute care
   b. Inpatient rehabilitation
   c. Geriatric: long term care or sub-acute rehabilitation
   d. Outpatient
   e. Pediatric
   f. Other (aquatic, hippo therapy, school system)