CLINICAL FACILITY EXPERIENCE DOCUMENTATION

Physical Therapist Assistant Program
Cecil College
One Seahawk Drive, North East, MD 21901

Name of Applicant (PLEASE PRINT): ________________________________________________________________

MUST BE FILLED OUT AND SIGNED BY THE PT CLINIC SUPERVISOR.
(Signature line is on the back 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. 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 member 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)