



PTA Observation Verification Form

Name of Prospective Student: _____

Contact Email/Phone #: _____

To be completed by the PT/PTA

Name of Facility: _____

Phone Number of Facility: _____ Date(s) of Observation: _____

Times of Observation: _____ Total Hours: _____

Type of Observation: In-patient Out-patient

To **satisfactorily** complete the observation experience the student must:

- 1. Arrive promptly at the scheduled time;
- 2. Dress appropriately for the healthcare facility;
- 3. Communicate with the PT/PTA, facility staff and patients appropriately; and
- 4. Demonstrate an interest in the observation experience.

Additional comments: _____

By signing below, I am acknowledging that the above-named person has completed the identified number of hours of observation **satisfactorily** under my supervision at the facility and on the date(s) identified above. **Any alterations to the information listed above must be initialed by the professional named below or the form will be invalid.**

Printed Name (must be a PT or PTA)

Signature & Credentials

Date