UNIVERSITY OF PUERTO RICO
MEDICAL SCIENCES CAMPUS
SCHOOL OF HEALTH PROFESSIONS
DEPARTMENT OF GRADUATE PROGRAMS
PHYSICAL THERAPY PROGRAM

CLINICAL OBSERVATION FORM FOR DPT APPLICANTS

Applicant Name _____

Instructions for Applicant: As part of the admission requirements to the Physical Therapy Program (DPT degree), you must complete a total of 30 observation hours in a physical therapy practice setting under the supervision of a licensed physical therapist. The experience may either be voluntary services, observation or shadowing a **clinical physical therapist**. The required hours **should be completed during the last two years before submitting the application to the program**. This form was created to document the observation experiences; must be completed by the supervising physical therapist; and should be submitted as part of the application package. You are required to comply with the dress code as well as with other rules or regulations established by the physical therapy practice setting. You should not to interfere with patient care during the observation hours. In order to comply with the observation hours, **you can observe from one to a maximum of three settings; a minimum of 10 hours of observation in each setting is required**. Observation hours will be verified.

Instructions to Supervising Physical Therapist: We appreciate your commitment to the physical therapy profession by allowing students to observe or volunteer in your facility. Please complete this form with the observational details and provide the student with a copy of your current recertification of professional physical therapist's license.

COMPLETE ONE FORM FOR EACH SETTING

Facility Name: _____ Telephone: _____

Address: _____

Type of Physical Therapy Services Provided at this Facility:
_____

Type of Experience: □ Voluntary Services □ Observation/Shadowing

Date(s) of Experience: _____ Number of Hours: _____

The following patient related activities were observed (please list):

I hereby certify that the information above is correct and accurate.

Physical Therapist Name: _____ Signature: _____

License Number: _____ Date: _____

Attach a copy of current recertification of the physical therapist's license to this completed form.

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