CLINICAL OBSERVATION RECORD

APPLICANT INFORMATION **Name ______________________Phone (opt)____________**

Upon completion of the observation requirement, it is expected that the applicant will be able to describe in general terms, the nature of physical therapy practice and to state why he/she has chosen to pursue a career as a Physical Therapist Assistant.

Physical Therapy Facility ____

Applicant Status: ______ Observer ______ Volunteer ______ Employee

If volunteer or employee, describe duties: ____

The Family Education Rights and Privacy Act of 1974 extends to students the right to inspect and review application materials. The law also permits the student to sign a waiver relinquishing his/her rights to inspect such material.

I do ______/ do not ______ waive my right to review the content of this form.

Applicant Signature ____________________________________ Date _________________

CLINICIAN INFORMATION

The purpose of this observation requirement is to acquaint the applicant with the nature and scope of the Physical Therapy profession, and expose him/her to a variety of physical therapy practice settings. The following information must be completed and signed either by a Physical Therapist or Physical Therapist Assistant, then returned to the address below. If the applicant has waived rights to review this form, and you wish to give the form to the candidate, please place it in an envelope, seal the envelope and place your signature across the sealed flap.

PLEASE CONSIDER THE FOLLOWING BEHAVIORS

		4	3	2	1	NA
1.	Applicant arrived on time and stayed for agreed upon hours.					
2.	Applicant's appearance/dress was neat and appropriate.					
3.	Applicant displayed effective listening skills and good verbal communication skills.					
4.	Applicant observed attentively and with interest.					
5.	Applicant's behavior showed confidence and enthusiasm.					
6.	Applicant's questions and comments indicated a desire to learn about the field of physical therapy.					

Note: 4 = yes/excellent 1 = no/poor

HOURS OBSERVED: ☐ **TYPE OF SETTING: inpatient** ☐ **outpatient** ☐

COMMENTS: ____

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SIGNATURE: ___________________________ **Please send to:** Physical Therapist Assistant Program
Murphy Hall 304
Missouri Western State University
4525 Downs Drive
St. Joseph, MO 64507

DATE: ________________

***CLINICIANS: PLEASE provide comments. They are important in the selection process. Points are given for any positive comments. No comment = 0 points. Negative comments result in deduction of points.**