**Name of Facility:**

**Street Address for Facility:**

**City:** **State:** **Zip/Postal Code:**

**Name of Medical Care Provider:**

**PT / PA License Number:** **State of License:**

**PT / PA Email:** **Phone #:**

**Date** **Time** **Signature of Medical Care Provider**

**Type of Experience:** Inpatient Outpatient Paid Volunteer Both

**Therapy Settings:**

Acute Care Outpatient Clinic (Private Practice)

Rehab/Sub Acute Rehab School/Pre-School

Extended Care Facility/Nursing Home/Skilled Nursing Facility Wellness/Prevention/Fitness

Industrial/Occupational Health Other (describe):

**Specialty Area(s) Observed and Hours of Experience in Each Area:**

Cardiovascular & Pulmonary Hrs: Neurology Hrs: Sports Hrs:

Clinical Electrophysiology Hrs: Orthopedics Hrs: Women’s Health Hrs:

Geriatrics Hrs: Pediatrics Hrs:

Other (describe): Hrs:

**Total # of Hours Over Span of Experience:**