Kankakee Community College
Physical Therapy Observation/Volunteer or Work Verification
PHYSICAL THERAPIST ASSISTANT PROGRAM

Applicant name (please print) Last: _____ First: _____ Middle: _____

KCC ID no. : _____ Email: _____

Address: _____ City: _____ State: ____ Zip code: _____ Phone: _____

Applicants to the Physical Therapist Assistant program at KCC must ***complete 10 (ten) documented*** hours of observation/volunteer time in physical therapy or 200 hours work in a physical therapy setting. Observation/volunteer experience must occur in at least two different settings, including ***five (5) hours*** in either a ***hospital acute care, hospital inpatient rehab, or nursing home*** setting. The supervisor must be a ***licensed physical therapist or physical therapist assistant***. Facility orientation or other requirements that may be mandatory to observe/volunteer/work should not be included in the hours submitted on this form. Hours may be completed at more than one facility. Submit this verification form by the application deadline.

Note to the applicant: Health care organizations and physical therapy clinics are not obligated to allow you to complete observation hours. Their willingness to offer these opportunities demonstrates a commitment to the physical therapy profession and an investment in future clinicians. Although you are otherwise NOT affiliated with KCC's PTA program, should you be accepted to KCC's PTA program, these facilities are potential clinical sites and employers. When you complete observation hours to be eligible for KCC's PTA program, you are a guest in the facility and are expected to demonstrate professionalism in dress, behavior, and attitude during ALL observation experiences. Wear dress casual (no jeans, unkempt or immodest clothes, or sandals), maximize your observation experience by being engaged (no cell phones or electronics), and be on time. Communicate the expectations to the facility and provide this form to the necessary individuals to complete and submit to KCC. If observation/volunteer or work experience occurs in multiple facilities, complete one form per facility. The information provided is subject to verification. It is your responsibility to ensure all documentation is submitted and your application is complete.

To be completed by the supervisor of the physical therapy observation/volunteer or work experience.

Name of facility: _____

Address: _____ City: _____ State: ____ ZIP code: _____ Phone: _____

Type of setting and hours

Inpatient setting (check all that apply): _____ hours
- ☐ Acute care
- ☐ Rehab/Subacute rehab
- ☐ Extended care/Nursing home/Skilled Nursing Facility
- ☐ Other (please specify): _____

Outpatient setting (check all that apply): _____ hours
- ☐ Outpatient clinic/private practice
- ☐ Hospital-based outpatient
- ☐ Other (please specify): _____

Specialty settings (check all that apply): _____ hours
- ☐ Home Health
- ☐ Industrial/Workplace/Occupational
- ☐ School/Preschool
- ☐ Wellness/Prevention/Sports/Fitness
- ☐ Other (please specify): _____

Observation/volunteer experience verification of hours:

Total observation/volunteer hours at above noted facility: _____ hrs. during the period of _____/_____ (month / year) to _____/_____ (month / year)

Name of therapist/credentials (Please print): _____ License (state/number): _____

Work experience verification of hours:

Applicant worked a minimum of 200 hours at the above noted facility/setting from the dates of: _____/_____ (month / year) to _____/_____ (month / year)

Name of supervisor completing form (Please print): _____ Title: _____

Professional and Interpersonal Behavior Rating Scale:

Provide feedback on the applicant's professional and interpersonal behavior based on your experience/knowledge of the applicant.

Attendance and punctuality:	☐Exceeds expectations	☐Meets expectations	☐Unacceptable
Attitude:	☐Exceeds expectations	☐Meets expectations	☐Unacceptable
Initiative:	☐Exceeds expectations	☐Meets expectations	☐Unacceptable
Professional appearance:	☐Exceeds expectations	☐Meets expectations	☐Unacceptable

Signature verifies accuracy of the information provided. _____ (**Signature**) _____ (**Date**)

Please submit this form directly to a Health Careers Advisor at KCC.
Fax to: 815-802-8101. Mail to: Kankakee Community College, Student Services, Health Careers Advisor, 100 College Drive, Kankakee, IL 60901

Updated 4/30/2021