

## Instructions for the Observation & Recommendation Form

### Instructions for Students – PART I

- Print applicant name and contact information
- Print clinic site name and contact information
- Provide beginning date, end date and total observation hours
- BE SURE TO USE THE CORRECT FORM FOR INPATIENT/OUTPATIENT/BONUS
- Indicate the patients and/or settings observed providing PT services
- Sign and date the declarations.
- Provide this form to a licensed PT or PTA for completion of PART II.

### Instructions for Clinicians – PART II

- The Observation and Recommendation form must be completed by a licensed PT or PTA
- The person completing the form should be the person who spent a significant amount of the time with the student.
- Observation and Recommendation forms are not accepted from relatives of the applicant.
- Once the applicant signs the waiver, they are NEVER allowed to see the Observation and Recommendation Form.
- The therapist's honest and forthright responses are essential to the application and selection process.
- Please contact the PTA program office with any questions about either the recommendation process, or the PTA program at KSU.
- **FAX or mail the Observation and Recommendation Form before the September 1<sup>st</sup> application deadline**

#### *Physical Therapist Assistant Program*

Kent State University at Ashtabula

FAX: 440-964-4355

3300 Lake Rd. West

Phone: 440-964-4252

Ashtabula, Ohio 44004

### Thank You Clinicians:

The time you take to introduce future PTA student to the physical therapy profession is very much appreciated. Your recommendation is used to help determine which applicants are selected for the incoming class in the Physical Therapist Assistant Technology Program at Kent State. We hope this process is enjoyable for you, and rewarding for the applicant. We truly appreciate your honest and candid opinion.

**Kent State University Physical Therapist Assistant Program**  
**2021 INPATIENT Observation & Recommendation Form**

**PART I: Completed by Applicant**

Applicant Name (print) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ KSU Email \_\_\_\_\_

Clinic Site Name \_\_\_\_\_ PT Dept. Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Observation Dates \_\_\_/\_\_\_/\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_

Total Hours at this Clinic \_\_\_\_\_

**Applicant Declarations:**

- *I am aware that any dishonesty will disqualify my application to PTST technical study.*
- *My signature waives my right to review this completed form.*

**Check all observed PT services.**

<input type="checkbox"/> Acute care	<input type="checkbox"/> Pediatrics
<input type="checkbox"/> Sub acute care	<input type="checkbox"/> Geriatrics
<input type="checkbox"/> Skilled Nursing	<input type="checkbox"/> Athletes
<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Wellness Center
<input type="checkbox"/> Home Health	<input type="checkbox"/> School
<input type="checkbox"/> Hospital	<input type="checkbox"/> Private Practice

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

**PART II: Completed by a LICENSED PT or PTA**

Rate the applicant on each of these behavioral characteristics as demonstrated during the observation time. (Please mark one box for each characteristic)

CHARACTERISTIC	Good	Fair	Poor
1. Reliability / Accountability			
2. Verbal / Non-verbal Communication			
3. Interpersonal Skills			
4. Inquisitiveness, Motivation & Independence			
5. Professionalism, Maturity, Ability to work with others			
6. Intellectual Potential, Judgment & Common Sense			

**Recommendation of this applicant.** (Select One)

Highly recommended

Recommended

Recommended with reservation

Not recommended

Evaluating Therapist Name (print) \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ State & License # \_\_\_\_\_

**MAIL or FAX directly to KSU PTA Program FAX: 440-964-4355**

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- Indicate the patients and/or settings observed providing PT services
- Sign and date the declarations.
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**Kent State University Physical Therapist Assistant Program**  
**2021 OUTPATIENT Observation & Recommendation Form**

**PART I: Completed by Applicant**

Applicant Name (print) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ KSU Email \_\_\_\_\_

Clinic Site Name \_\_\_\_\_ PT Dept. Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Observation Dates \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Total Hours at this Clinic \_\_\_\_\_

**Applicant Declarations:**

- *I am aware that any dishonesty will disqualify my application to PTST technical study.*
- *My signature waives my right to review this completed form.*

**Check all observed PT services.**

__ Acute care	__ Pediatrics
__ Sub acute care	__ Geriatrics
__ Skilled Nursing	__ Athletes
__ Rehabilitation	__ Wellness Center
__ Home Health	__ School
__ Hospital	__ Private Practice

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

**PART II: Completed by a LICENSED PT or PTA**

Rate the applicant on each of these behavioral characteristics as demonstrated during the observation time. (Please mark one box for each characteristic)

CHARACTERISTIC	Good	Fair	Poor
1. Reliability / Accountability			
2. Verbal / Non-verbal Communication			
3. Interpersonal Skills			
4. Inquisitiveness, Motivation & Independence			
5. Professionalism, Maturity, Ability to work with others			
6. Intellectual Potential, Judgment & Common Sense			

**Recommendation of this applicant.** (Select One)

Highly recommended

Recommended

Recommended with reservation

Not recommended

Evaluating Therapist Name (print) \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ State & License # \_\_\_\_\_

**MAIL or FAX directly to KSU PTA Program**

**FAX: 440-964-4355**

<p style="text-align: center;"><b>Instructions for the Observation &amp; Recommendation Form</b></p>
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## Kent State University Physical Therapist Assistant Program

### 2021 **BONUS** Observation & Recommendation Form

**PART I: Completed by Applicant**

Applicant Name (print) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ KSU Email \_\_\_\_\_

Clinic Site Name \_\_\_\_\_ PT Dept. Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Observation Dates \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Total Hours at this Clinic \_\_\_\_\_

**Applicant Declarations:**

- *I am aware that any dishonesty will disqualify my application to PTST technical study.*
- *My signature waives my right to review this completed form.*

**Check all observed PT services.**

- |  |   |
|--|---|
| <input type="checkbox"/> Acute care      | <input type="checkbox"/> Pediatrics       |
| <input type="checkbox"/> Sub acute care  | <input type="checkbox"/> Geriatrics       |
| <input type="checkbox"/> Skilled Nursing | <input type="checkbox"/> Athletes         |
| <input type="checkbox"/> Rehabilitation  | <input type="checkbox"/> Wellness Center  |
| <input type="checkbox"/> Home Health     | <input type="checkbox"/> School           |
| <input type="checkbox"/> Hospital        | <input type="checkbox"/> Private Practice |

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

**PART II: Completed by a LICENSED PT or PTA**

Rate the applicant on each of these behavioral characteristics as demonstrated during the observation time. (Please mark one box for each characteristic)

CHARACTERISTIC	Good	Fair	Poor
1. Reliability / Accountability			
2. Verbal / Non-verbal Communication			
3. Interpersonal Skills			
4. Inquisitiveness, Motivation & Independence			
5. Professionalism, Maturity, Ability to work with others			
6. Intellectual Potential, Judgment & Common Sense			

**Recommendation of this applicant.** (Select One)

- Highly recommended
- Recommended
- Recommended with reservation
- Not recommended

Evaluating Therapist Name (print) \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ State & License # \_\_\_\_\_

**MAIL or FAX directly to KSU PTA Program**

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