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 1st 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:

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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.

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)

<table>
<thead>
<tr>
<th>CHARACTERISTIC</th>
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Evaluating Therapist Name (print)________________________________________ Date __________

Signature ___________________________________________ State & License # ___________

Recommendation of this applicant. (Select One)

□ Highly recommended
□ Recommended
□ Recommended with reservation
□ Not recommended

Check all observed PT services.

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

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