CLINICAL HOURS FORM

Carroll Community College
Physical Therapist Assistant Program
1601 Washington Road
Westminster, MD 21157

Applicant Name:	

Clinic Name:	
Address:	
Phone:	
Email:	
Primary supervisor, volunteer coordinator: *(This is the person who should sign and verify the hours)*	
Total number of hours completed:	

Completed as:

- ◯ volunteer
- ◯ employee
- ◯ observer
- ◯ patient

This setting is primarily: _____

(Settings could be: outpatient orthopedics; aquatics, women's health; skilled nursing; acute hospital; acute rehab; home health; federal/state facility; pediatrics)

I verify that these hours were completed,

_____

Signature Date

IF THE APPLICANT PERFORMED HOURS IN TWO DIFFERENT AREAS OF YOUR CLINIC (E.G. OUTPATIENT ORTHO AND THEN IN AQUATICS) A SEPARATE PAPER MUST BE COMPLETED FOR EACH SETTINGS