Blinn College PTA Program
Documentation of Physical Therapy Experience Form

Student Name: _____

Facility Name: _____

Facility Address: _____

Type of Setting: Acute care/Hospital Outpatient Skilled Nursing
(Circle all that apply) Aquatics Inpatient Rehab Pediatrics Home Health

Date	Time In	Time Out	Total time

Total Hours: _____

Therapist Signature: _____

Therapist Printed Name: _____

Therapist or Clinic Email: _____

*In order to meet the requirements for application, all applicants must provide a valid email address to complete an evaluation for EACH facility where the student has shadowed.