PHYSICAL THERAPIST ASSISTANT PROGRAM

CLINICAL EXPERIENCE LOG

Volunteer Name

Name of Clinical Facility

Type of Facility
(Acute Care, Rehab, Outpatient, etc.)

Address

A separate form should be submitted for each clinical facility.

DATE	ACTIVITIES	TIME IN	TIME OUT	TOTAL TIME	PT/PTA INITIALS
		***TOTAL (Hours)**			

*A minimum of 8 hours of volunteer/work experienced required. 4 hours must be in an acute care setting.

By signing below, I verify that this student has completed the clinical experience documented above.

Signature (include credentials) Date Position Phone