BISHOP STATE COMMUNITY COLLEGE
PHYSICAL THERAPIST ASSISTANT PROGRAM

VERIFICATION OF WORK/VOLUNTEER HOURS

Please complete the following information and upload into the PTA CAS by May 15th.

Name of Applicant (print)____

Signature of Applicant____

Name of Facility____

Type of Facility____

PT Department Director____

PT/PTA

Supervisor____

Dates of Employment/Volunteer Service____

Type of Experience Observed____

Total hours___________________ Volunteers hours________________Paid hours__________________

Please indicate whether this is the 1st _________ 2nd_________ 3rd _______ or other ____experience. A verification of hours and student evaluation form will be sent to the person below:

Name of PT/PTA verifying the hours/evaluation________________________ License#______________

Print___________________________________ Signature____

Preferred method of contact: email address ____

Fax: ____

Revised 07/2021