



**BISHOP STATE COMMUNITY COLLEGE
PHYSICAL THERAPIST ASSISTANT PROGRAM**

VERIFICATION OF WORK/VOLUNTEER HOURS

Please complete the following information and mail or hand deliver to the Bishop PTA program office. To ensure the deadline is met, it is required that the form be in the program office 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 07/2019