



Health Programs
Perdue Hall
800 College Court
New Bern, NC 28562
252-638-1168
(Fax) 252-638-4795

www.cravencc.edu

PTA Program Observation Hours Verification Form

The Physical Therapy Assistant (PTA) Program at Craven Community College requires applicants to obtain at least 16 hours of observation in **two** separate settings, as a volunteer, with a licensed Physical Therapist or PTA, within the date range of February 1, 2023 through May 31, 2023.

Upon completing this form, the PT/PTA that was observed must place it in a sealed envelope with their signature across the seal. Applicant is to return the sealed envelope to the: Brittany Ipock, Admissions & Advising Coordinator – Health Programs, 800 College Court, Perdue Hall Room 101G, New Bern, NC 28562, no later than May 31, 2023.

Following observation the applicant is to write a 250 - 500 word reflection discussing the interaction between the PTA/ PT and the patients they were treating. What treatments did you observe? Did you observe any alterations in treatment from one patient to another? How did you feel when you saw a positive interaction between the clinician and a patient? Once your reflection is complete, place it in a separate envelope from the signed verification form envelope. Submit the two envelopes together prior to the deadline. **Forms must be received by Health Programs no later than May 31st, 2023.**

Applicant Name: _____ **Student ID #:** _____
Email: _____ **Applicant Phone #:** _____

Name of Facility: _____
Address of Facility: _____
City: _____ **State:** _____ **Zip code:** _____
Phone # of Facility: _____
Name of clinician observed: _____
Credentials of clinician observed: _____
State and license # (to be kept confidential): _____
Email: _____

PT setting where observation occurred (choose *TWO* different settings):

<input type="checkbox"/> Acute Care	<input type="checkbox"/> Outpatient Clinic (Private Practice)
<input type="checkbox"/> Rehab/Sub Acute Rehab	<input type="checkbox"/> School/Pre-School
<input type="checkbox"/> Extended Care Facility/Nursing Home	<input type="checkbox"/> Wellness/Prevention/Fitness
<input type="checkbox"/> Skilled Nursing Facility	<input type="checkbox"/> Industrial/Occupational Health
<input type="checkbox"/> Home Health	<input type="checkbox"/> Other (please specify): _____

Dates and times of observation:

Date: _____	Time in: _____	Time out: _____
Date: _____	Time in: _____	Time out: _____
Date: _____	Time in: _____	Time out: _____
Date: _____	Time in: _____	Time out: _____
Date: _____	Time in: _____	Time out: _____

Signature of Licensed PT/PTA

Date

Updated 1.10.2023

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