UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
SCHOOL OF HEALTH RELATED PROFESSIONS
DEPARTMENT OF PHYSICAL THERAPY

VERIFICATION OF OBSERVATION FORM
(Form may be duplicated)

Name of Facility/Clinic: ____________________________
(Note: Submit one form for each type of facility or clinic.)

Type of Facility/Clinic**: 
- Acute Care Hospital
- Sub-acute Rehab Hospital (inpatient)
- Private Practice
- Hospital-based Outpatient Clinic
- Home Care
- Skilled Nursing Facility/Extended Care
- School System
- Industry
- Other (specify) ____________________________

General Diagnoses: 
(Check all that apply)
- Musculoskeletal
- Neuromuscular
- Other Systems
- Cardiovascular/Pulmonary
- Variety of age ranges

Age Range: 
- Birth to 21 years
- 21 to 65 years
- > 65 years

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<tr>
<th>Observation Dates (mm/dd/yy)</th>
<th># hours ***</th>
<th>PT's printed name</th>
<th>PT License #</th>
<th>PT's signature</th>
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***A maximum of 20 hours may be used from any one observation site; no more than 20 total hours earned from all internships will be counted. Enter specific dates of each observation (refer to instructions). Hours accrued during employment are not acceptable.

Note: Observation hours must be completed in the current year of application, and all documentation must be received by the registrar's office on or before the application deadline of November 1 to be considered for admission. Applicants are responsible for submitting forms.

This certifies that ____________________________ (applicant) observed for a total of _______ hours in this physical therapy facility in partial fulfillment of admissions requirements for the Department of Physical Therapy, the School of Health Related Professions, and the University of Mississippi Medical Center.

**Physical Therapist: ____________________________ **PT License #: __________________

(**Form must be signed by a licensed physical therapist with license number included.)

Upload the completed and signed form to the Workday application portal.