Name: ____________________________________________

Application Number: ______________________________

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:

- _____ Musculoskeletal
- _____ Neuromuscular
- _____ Other Systems
- _____ Cardiovascular/Pulmonary

Age Range:

- _____ Birth to 21 years
- _____ Variety of age ranges
- _____ 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.