Application Number:				
		UNIVERSITY OF MISSISSIPPI N SCHOOL OF HEALTH RELATE DEPARTMENT OF PHYSIC	D PROFESSIONS	
		VERIFICATION OF OBSI (Form may be d		
Name of Facility/Clinic:		e: Submit one form for each type	of facility or clinic.)	
Type of Facility/Clinic**: — — — — —		Private Practice Home Care	Sub-acute Rehab Hospital (inpatient) Hospital-based Outpatient Clinic Skilled Nursing Facility/Extended Care Industry	
General Diagnoses: (Check all that apply)		Musculoskeletal Integumentary	Neuromuscular Cardiovascular/Pulmonary	
Age Range:		Birth to 21 years Variety of age ranges 21 to 65 years > 65 years		
Observation Dates (mm/dd/yy)	# hours ***	PT's printed name	PT License #	PT's signature
	-	rom any one observation site; no mo		
Note: Observation hours on or before the a	must be complet pplication deadli		and all documentation	oyment are <u>not</u> acceptable. must be <u>received</u> by the registrar's office ts are responsible for submitting forms by
facility in partial fulfillm	ent of admissio	(applicant) obserting (applicant) obse		hours in this physical therapy y, School of Health Related
Physical Therapist:(Form must be signed by a licensed physical t			**PT License #:	
				e # included.)
Mail or Fax completed		ice of Student Services and Regist iversity of Mississippi Medical Cer		

Application for Class Entering: 2018

Name: __

2500 N. State Street
Jackson, MS 39216-4505
Fax #: 601-984-1079