

Name: \_\_\_\_\_

Application for Class Entering: 2018

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  
(Check all that apply) \_\_\_\_\_ Integumentary      \_\_\_\_\_ 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

\*\*\*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 by mail or fax to the Office of Student Services and Registrar.

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, School of Health Related Professions, and University of Mississippi at the Medical Center.

\*\*Physical Therapist: \_\_\_\_\_ \*\*PT License #: \_\_\_\_\_  
(\*\*Form must be signed by a licensed physical therapist with license # included.)

Mail or Fax completed forms to: Office of Student Services and Registrar  
University of Mississippi Medical Center  
2500 N. State Street  
Jackson, MS 39216-4505  
Fax #: 601-984-1079