MORGAN
COMMUNITY COLLEGE

DOCUMENTATION OF VOLUNTEER OR WORK EXPERIENCE IN A PHYSICAL THERAPY SETTING

Name of Applicant: _____

Name/Title of Supervising Clinician: _____

Name of Facility: _____

Address: _____

_____

CITY **STATE** **ZIP**

Clinical Setting: **Inpatient** ____ **Outpatient** ____ **Skilled/Rehab** _____

Total Number of Hours: _____

Primary Clientele: **Orthopedic** ____ **Neurologic** ____ **Pediatric** ____**Other** ____

This is to verify that the applicant named above has completed a <u>minimum of 12 hours</u> at our facility in the following capacity within the past two years:

- ____ **Volunteer/Observation**
- ____ **Student Internship with Direct Patient Care**
- ____ **Paid Rehab Tech/Aide with Direct Patient Care**

Comments:

_____
_____
_____

Signature/Title: _____

Submit by May 13, 2022, to Jeffrey.Coon@morgancc.edu