

# PHYSICAL THERAPY PROGRAM

## University of Wisconsin – La Crosse, Madison, and Milwaukee

### Patient Care Experience Form

Applicant Name: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Application Deadline: \_\_\_\_\_ (Form must be received by this date.)

#### To the Applicant:

Forty (40) hours of either paid or volunteer patient care experience in **two distinctly different** physical therapy patient care settings (e.g., Inpatient Rehabilitation, Acute Care, Subacute Care, Outpatient Orthopedics, Pediatrics, Skilled Nursing Facility, Schools, Home Health) under the supervision of a licensed physical therapist are required for admission. The two distinctly different experiences may occur within one institution; however, the patient populations must not overlap. It is vital that this directive is followed as it insures that each applicant has appropriate exposure to diverse patient populations. There must be a minimum of 20 hours in each setting. This experience may be either observational or participatory but **MUST INVOLVE DIRECT PATIENT CARE.**

The applicant completes this portion of the form. The form must be completed by a licensed physical therapist. The applicant may submit this form (or a copy of this form) with other application materials or the form may be sent directly to the DPT Program. Failure to return this completed form by the deadline will result in loss of eligibility for admission to the Program. **Please use one form for each setting.**

Facility Name \_\_\_\_\_ Facility Location (City, State) \_\_\_\_\_

Type of Setting \_\_\_\_\_ Number of Hours \_\_\_\_\_ (volunteer) \_\_\_\_\_ (paid)

Date of Experience: from \_\_\_\_\_ to \_\_\_\_\_

Patient-related activities which I observed/performed:

Valuable insights into the physical therapy profession that I acquired from this experience:

Under the Family Education Rights and Privacy Act of 1974 (Buckley Amendment), you are entitled to review this form or to waive your right to access. If you do not waive this right, and request to review the form, you will be provided with a copy. Please check the appropriate box and sign below before giving this form to the physical therapist.

- I waive my right to review this Patient Care Experience form.  
 I refuse to waive my right to review this Patient Care Experience form.

Name (please print) \_\_\_\_\_ Signature \_\_\_\_\_

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## University of Wisconsin – La Crosse, Madison, and Milwaukee

Patient Care Experience Form Applicant Name: \_\_\_\_\_

### To the Supervising Physical Therapist:

Listed below are qualities that are crucial in physical therapy students and practicing physical therapists. For each category below, please rate the applicant on the 1 to 5 **scale (1=poor, 5=excellent)** AND make comments or cite examples. If you wish to go into greater detail than this space allows, feel free to attach a letter. Thank you for this valuable contribution to the application process for future physical therapists. The information you provide is significant in the evaluation of this applicant for entry into the Physical Therapy Program at **UW–La Crosse, Madison, or Milwaukee**.

1. **Commitment to Learning:** The ability to self assess, self correct and self direct; identify needs and sources of learning; continually seek new knowledge and understanding.

1 2 3 4 5

2. **Interpersonal Skills:** The ability to interact effectively with patients, families, colleagues, other health care professionals and the community; deal effectively with cultural/ethnic diversity issues.

1 2 3 4 5

3. **Communication Skills:** The ability to communicate effectively (speaking, body language, reading, writing, listening) for varied audiences and purposes.

1 2 3 4 5

4. **Effective Use of Time and Resources:** The ability to obtain the maximum benefit from a minimum investment of time and resources.

1 2 3 4 5

5. **Use of Constructive Feedback:** The ability to identify sources of feedback and to seek out feedback; to effectively use and provide feedback for improving personal interaction.

1 2 3 4 5

6. **Professionalism:** The ability to exhibit appropriate professional conduct and to represent the profession effectively (attitude, demeanor and appearance appropriate for health care setting).

1 2 3 4 5

7. **Responsibility:** The ability to fulfill commitments and be accountable for actions and outcomes.

1 2 3 4 5

### If there were a PT aid position available:

\_\_\_\_\_ I would consider hiring this person \_\_\_\_\_ I would NOT hire this person \_\_\_\_\_ I am not able to say at this time

\_\_\_\_\_  
Supervising Physical Therapist **Printed** Name State Licensure Number

\_\_\_\_\_  
Supervising Physical Therapist Signature Date  
(NOT VALID without licensed therapist signature)