Department of Physical Therapy and Rehabilitation Sciences
School of Allied Health
The University of Kansas Medical Center

Clinical Observation Verification

Applicant Name _____

This is to certify that _____ observed in our Department of
(applicant's name)

Physical Therapy under the direction of a physical therapist for a total of _____ hours in

_____
(month, year)

_____
Physical Therapist's name

_____
Physical Therapist's signature

_____
Facility name

_____
City, State

_____
Type of facility (e.g., hospital, private practice, school)

_____
Type of patients observed