Sacred Heart UNIVERSITY

Documentation of Volunteer Hours

This form is to be completed by the applicant and verified by the Physical Therapist supervising the experience.

Applicant's Name:_____

Facility Name/Address:_____

Experience Setting (acute, rehab, outpatient, etc.): _____

Facility Phone #:(_____)_____

Contact Person: _____

Start Date: _____ End Date: _____

Total # of observation hours: _____

Description of Observation (patient diagnoses; categories of practice observed such as orthopedics, pediatrics, geriatrics, neurology, wellness; specialty practice observed such as NICU, aquatics, vestibular etc.)

This is to certify that _____ attended
APPLICANT NAME

_____ from _____ to _____
NAME OF FACILITY DATE DATE

for a total of (specify # of hours) _____.

_____ _____
PHYSICAL THERAPIST SIGNATURE DATE