GENESEE COMMUNITY COLLEGE
PTA Program
Volunteer/Work Experience Recommendation Form

APPLICANT's NAME ____________________________________________________________.
S.S #____________________________________

Overall, I would rate the applicant as follows:  (Please check 1 box)
{  } Recommend for PTA Program
{  } Do NOT recommend for PTA Program  REASON (Please Comment):________________________

Applicant:  Please complete the above information, sign the waiver to release this information, and give this form to the person who supervised your volunteer/work experience in physical therapy.

WAIVER:  Pursuant to the Family Education Rights and Privacy Act (Buckley Amendment) signed into law on December 31, 1974, I the undersigned, DO ___ DO NOT ___, waive my right of access to inspect and review this letter of recommendation.
________________________________________________
(Signature)

We request that applicants complete a minimum of twenty (20) hours of experience in a physical therapy environment.  We would appreciate your verification of the applicant's experience by completing this form and returning it directly to us at the address specified below at your earliest convenience.

Applicant's relationship to your facility:    ____ Volunteer     ____ Employee

Type of clients served by your facility: ___________________________________________________________

Total number of hours applicant participated in a physical therapy environment:  _______ hours  Dates: ______________________

Identify as closely as possible the number of hours (or percent time) the applicant spent in each of the following activities:

________ Observation of PT treatment sessions

________ Observation of other patient care activities (eg, OT, speech)

________ Participation in non-direct patient care activities (eg, clean treatment areas, wrap hot packs)

________ Participation in direct patient care activities (eg, sit with patient during treatment, assist therapist, transport patients)

COMMENTS:
_____________________________________________________________________________________________________

____________________________________________________________________________

Name of facility ________________________________________________________________

Address ____________________________________________________________

Name of person completing form___________________________________________ Date

Title __________________________ Telephone (______)__________________________

Signature __________________________

NY License #:_______________________

Please Mail this form to:

Physical Therapist Assistant Program
Genesee Community College
1 College Road
Batavia, NY 14020

THANK YOU!