Physical Therapist Assistant Program

Hinds Community College

Physical Therapy Observation/Experience Form

Applicant Name: _____ Last 4 digits of SS#:_____

NOTE TO APPLICANT: *All patient information accessed in medical charts, through observation, or in any other manner is completely confidential. Any breach of patient confidentiality during or after your observation time will result in immediate dismissal of your physical therapist assistant program application and may be punishable in a court of law.*

Documented hours of observation should occur under a licensed physical therapist (PT) or physical therapist assistant (PTA) while they are providing direct patient care. Observation hours for the PTA program must be documented by the PT or PTA that was observed. The PT or PTA cannot be a relative of the applicant. Make as many copies of the form as necessary to document observation. Form(s) should be returned to ***nahcadmissions@hindscc.edu***

Date: _____

This is to verify that _____ observed in the physical
(applicant)

therapy department at _____ from _____ to _____
(clinic) (time) (time)

on _____.
(date)

Signed: _____
(observing therapist)

Thank you for allowing this applicant to observe in your department.

Angela Jordan, PT, Interim Program Director
Hinds Community College
PTA Program
1750 Chadwick Drive
Jackson, MS 39204
Angela.Jordan@Hindscc.edu

Patient Confidentiality and Release statement for observing Hinds Community College, Physical Therapist Assistant applicant. Every patient has the right to privacy and confidentiality. I understand that patients or confidential information will not be discussed in public areas such as hallways, elevators, stairwells, cafeterias, or any area where you can be overheard by someone who does not have a need to know this information. I also release _____ of any liability that may be occurred during my observation.

_____
(signature of observing applicant)