The individual who has asked to observe at your facility is interested in applying to the PTA program at Hawkeye; this observation is part of the admission requirements. They must have three observations with a PT or PTA, eight hours each, in three different settings. The 8-hour observations can be completed in one or more visits, depending on the facility’s preference. Please complete the information below to document that the student has completed the observation requirement. Thank you for your assistance with this process. If you have any questions or concerns please feel free to contact Melissa Schneider with the HCC PTA Program at 319-296-4434.

Name of Observer (STUDENT NAME): ______________________________________________

Observation 1
Facility Name: ____________________________________________________ Location/City: ________________________________

Facility Type/Observation setting:
Acute IP  OP Clinic  Home Health  Skilled Rehab Center  Other: __________________________

I verify that I am a PT or PTA and the above-named individual observed with me for a total of 8 hours.

Clinician Name: ___________________________  Clinician License #: ____________________

Clinician Signature: ___________________________  Date: ____________________________

Observation 2
Facility Name: ____________________________________________________ Location/City: ________________________________

Facility Type/Observation setting:
Acute IP  OP Clinic  Home Health  Skilled Rehab Center  Other: __________________________

I verify that I am a PT or PTA and the above-named individual observed with me for a total of 8 hours.

Clinician Name: ___________________________  Clinician License #: ____________________

Clinician Signature: ___________________________  Date: ____________________________

Observation 3
Facility Name: ____________________________________________________ Location/City: ________________________________

Facility Type/Observation setting:
Acute IP  OP Clinic  Home Health  Skilled Rehab Center  Other: __________________________

I verify that I am a PT or PTA and the above-named individual observed with me for a total of 8 hours.

Clinician Name: ___________________________  Clinician License #: ____________________

Clinician Signature: ___________________________  Date: ____________________________

THE LICENSED PT/PTA SHOULD SIGN WHERE NOTED AND UPON COMPLETION, THE STUDENT WILL RETURN THE FORM TO THE HCC PTA PROGRAM (to Melissa Schneider, HESC 228C) BY THE END OF THE FALL SEMESTER PRIOR TO TECHNICAL PROGRAM ADMISSION.