VOLUNTEER EXPERIENCE FORM

APPLICANT’S NAME ____________________________________________________

I hereby waive my right to inspect this form and attachments of continuation. I understand I may not be required by the institution to waive that right as a condition for admission.

Date _____________________ Student Signature _______________________________________________________________

PLEASE NOTE: If the student does not sign the statement, the law specifically reserves to the student the right of access to the letter in question.

The above-named individual, who is seeking admission to our physical therapy program, has indicated that he/she volunteered or worked at your facility.

One criterion for admission is that an applicant must complete a minimum of forty (40) hours of experience in a PT setting providing direct patient/client care under the supervision of a Physical Therapist. This experience must be undertaken within two years prior to application in a maximum of two (2) settings.

During this experience we hope that the applicant has had the opportunity to observe interdisciplinary activities; observe patients/clients in a variety of situations; and, if permitted, participated in some direct patient/care activities.

We would appreciate your verification of the applicant’s experience by completing this form and returning or faxing it to the Director of Physical Therapy, Department of Rehabilitation Science, University at Buffalo, 501 Kimball Tower, Buffalo, NY 14214-3079 by November 1st; the fax number is 716-829-3217. Thank you for your cooperation.

Types of clients served by your Center: ____________________________________________________________________________

Total number of hours applicant participated in the volunteer experience as described above: Hours: __________________________

Dates (including year) _______________________________________________________________________________________
___________________________________________________________________________________________________________

*Quality of work:     Excellent _______   Good _______    Fair_______   Poor _______

Comments: (Additional pages may be attached)  ______________________________________________ ______________________
____________________________________________________________________________________ ________________________
_______________________________________________________________________________________ _____________________
____________________________________________________________________________________________________ ________

Name of Center _________________________________________________________________________________ _____________

Address  _______________________________________________________________________________________ _____________
No./Street                                                                                           City/State/Zip

Supervising Physical Therapist: __________________________________________________________________________________

Title ______________________________ Telephone (_______)________________________________________________________________

Signature __________________________________________     Telephone (_______)_______________________________________
     Date  __________________________________________

*Please note that only ratings of “Excellent” or “Good” will receive credit toward this requirement, so if you give a “Fair” or “Poor” rating, please provide us with specific information indicating why that rating was given.