DOCTOR OF PHYSICAL THERAPY PROGRAM

Department of Rehabilitation Science

School of Public Health and Health Professions 501 Stockton Kimball Tower, Buffalo, NY 14214

**VOLUNTEER EXPERIENCE FORM**

PLEASE PRINT CLEARLY

Applicant Name: Person #: Email Address:

(UB students only)

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

Date: Applicant Signature:

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.

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The above-named individual is seeking admission to our physical therapy program.

One criterion for admission is that an applicant must complete **forty (40) hours** of volunteer/observational experience in a PT setting, at a site that provides direct patient/client care while under the supervision of a **Physical Therapist**. 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, participate** in some direct patient/care activities. This experience must be undertaken within two years prior to application in a **maximum** of **two (2) settings**.

Remit the completed form to: Director of Physical Therapy, Department of Rehabilitation Science, University at Buffalo, 501 Kimball Tower, Buffalo, NY 14214-3079 by **November 1st**. You can also fax the completed form to: 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:

Dates volunteered (please include year):

# Quality of volunteer work

Please provide information on the overall quality of volunteer work provided by this applicant. Please consider such things as timeliness, appropriate appearance, adherence to rules/regulations, ability to interact with therapists and staff, ability to interact with service recipients, general conduct, and professionalism.

\*Overall, this volunteer demonstrated work that was: Excellent Good Fair Poor

Please provide any comments/ examples here. You may attach additional pages if desired.

Name of Center:

Address:

No./Street City/State/Zip

Supervising Physical Therapist’s Name:

Professional Title: Phone (Incl. Area Code): Date Signed:

Signature: Email:

**\*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.**

August 2018