

OBSERVATION HOURS

NOTE: ONLY ONE TYPE OF PHYSICAL THERAPY FACILTY PER PAGE

Type of Facility: **ACUTE**

(Includes hospital-based inpatients and wound care)

<u>Signature of Supervisor:</u> to include BOTH printed name with credentials & signature

		Time				SIGNATURE OF SUPERVISOR
Name of Facility	D-4-			Hours	1) Printed name w/ credentials	
·	Date				2) Signature	
						1)
			to			2)
			to			1)
			to			2)
						1)
			to			2)
						1)
			to			2)
						1)
			to			2)
			to			1)
					2)	
	TOTAL # OF HOURS					



OBSERVATION HOURS

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Type of Facility: **REHAB UNIT OR FACILITY**

Signature of Supervisor: to include BOTH printed name with credentials & signature

Name of Facility	Date	Time		Total # Hours	SIGNATURE OF SUPERVISOR	
					1) Printed name w/ credentials	
	Date				nouis	2) Signature
						1)
			to			2)
						1)
			to			2)
			to			1)
			to			2)
			to			1)
						2)
						1)
			to			2)
	to	to			1)	
					2)	
	TOTAL # OF HOURS					



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Type of Facility: **OUTPATIENT**

Signature of Supervisor: to include BOTH printed name with credentials & signature

Name of Facility		Time		Hours	SIGNATURE OF SUPERVISOR	
	Data				1) Printed name w/ credentials	
	Date				2) Signature	
						1)
			to			2)
						1)
			to			2)
			+0			1)
			to			2)
			to			1)
						2)
			to			1)
						2)
			to			1)
						2)
		TOTAL # OF HOURS				



OBSERVATION HOURS

NOTE: ONLY ONE TYPE OF PHYSICAL THERAPY FACILTY PER PAGE

Type of Facility: LONG TERM CARE

(Includes nursing homes, nursing facilities, and skilled nursing facilities)

Signature of Supervisor: to include BOTH printed name with credentials & signature

Name of Facility		Time			Total #	SIGNATURE OF SUPERVISOR	
	D-4-					1) Printed name w/ credentials	
	Date				Hours	2) Signature	
						1)	
			to			2)	
						1)	
			to			2)	
						1)	
			to			2)	
			+0	to		1)	
			ιο			2)	
						1)	
			to			2)	
						1)	
		to			2)		
		TOTAL # OF HOURS					



OBSERVATION HOURS

NOTE: ONLY ONE TYPE OF PHYSICAL THERAPY FACILTY PER PAGE

Type of Facility: **OTHER**

(Includes hippotherapy, aquatics, pediatrics, and home health care)

Signature of Supervisor: to include BOTH printed name with credentials & signature

						SIGNATURE OF SUPERVISOR
Name of Facility		Time			Total # Hours	1) Printed name w/ credentials
,	Date					2) Signature
						1)
			to			2)
						1)
			to			2)
			to			1)
						2)
			to			1)
						2)
			to			1)
						2)
						1)
		to			2)	
						2)
TOTAL # OF HOURS						

Applicant's Name	 	 	