STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

Physical Therapy Board of California
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VERIFICATION OF CLINICAL EXPERIENCE
PHYSICAL THERAPIST ASSISTANT EQUIVALENCY-SECTION 2655.3(a)

Section 1398.47 of the California Code of Regulations states in part "…18 months of the work experience shall be in providing patient related tasks under the orders, direction, and immediate supervision of a licensed physical therapist in an acute care inpatient facility." Therefore, it is necessary to report two separate totals for acquired work experience: 1) hours of work experience providing patient related tasks in an acute care inpatient facility, and 2) hours of work experience providing patient related tasks in all other types of health care settings.

INSTRUCTIONS: The supervising physical therapist must complete this form. Misrepresentation of the applicant's work experience hours by the undersigned supervising licensed physical therapist constitutes unprofessional conduct and could result in disciplinary action against the licensee. Indicate below which health care setting (i.e. Home Health, Skilled Nursing, etc.) this document represents. Respond to each question. All incomplete forms will be returned to the applicant. Complete one form for work experience received under each licensed supervising physical therapist. If additional forms are needed, you may copy this form. Attach a duty statement or job description identifying the clinical experience.

Applicant's Name: _____
First Last

The above-name applicant is applying for approval as a physical therapist assistant by equivalency. As the physical therapist who supervised the work experience of the above named physical therapy aide, please provide the Board with information requested in this form. You may only attest to that work experience which you directly observed and supervised.

Supervising Licensed Physical Therapist's Name: _____

Licensed #: _____ Work Telephone #: (_____) _____ Home Telephone #: (_____) _____

Name of Facility: _____

Address: _____
Street Address City State Zip Code

Applicant's dates of employment: _____/_____/_____ to _____/_____/_____
Month Day Year Month Day Year

In response to the following questions, do not include non-patient related tasks such as observation of the patient, transport of patients, physical support only during gait or transfer training, housekeeping duties, clerical duties and similar functions. Include only patient related tasks (e.g. ultrasound) which have been included in the patient treatment plan by the supervising physical therapist.

- **Acute Care Inpatient Facility**

How many hours has the physical therapy aide worked assisting the supervising physical therapist in the treatment of male and female patients, varying ages, and disabilities in an **acute care inpatient facility**? _____

- **Other Type of Health Care Setting** _____

How many hours has the physical therapy aid worked assisting the supervising physical therapist in the treatment of male and female patients, varying ages, and disabilities in a facility other than acute care? _____

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Licensed Physical Therapist Signature (Blue ink only) _____Date _____

I certify under penalty of perjury under the laws of the State of California that I was supervised for the hours listed above as specified by my supervising physical therapist.

Applicant Signature _____ Date _____

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