

PERSONAL INFORMATION

Name _____ Date _____

Address _____

Phone #'s: Cell _____ Home _____ Age: _____

EDUCATION

High School _____ Year of Graduation _____

College or Trade School _____ Number of years _____

GENERAL

Why are you interested in observing in a physical therapy facility? _____

What are your expectations of this experience? _____

NUMBER OF HOURS REQUESTED: _____

Dates available: _____

EMERGENCY CONTACT:

Name _____

Phone # _____

RELEASE OF LIABILITY:

I hereby release Advanced Physical Therapy Center of Stamford, LLC, its owners, managers, and staff of any and all liability involved with my participation as an intern or observer in this facility. If I am participating to fulfill a school requirement, I understand that my lack of effort can adversely affect my grade.

Intern or Observer Signature

Parent or Guardian Signature if HS student

Date