



School of Health and Environment
Department of Physical Therapy
3 Solomont Way, Suite 5
Lowell, Massachusetts 01854-5124
tel.: 978.934.4517
fax : 978.934.3006
web site: www.uml.edu/college/she/pt/

Clinical Observation Form

This is to certify that _____ has
completed _____ (hours) of volunteer or paid (please circle one) experience in
physical therapy at _____
from _____ (date) to _____ (date).

Signature

Title/Position

Phone/email address

Please return this form to:

Keith W. Hallbourg, PT, DPT, MS
Graduate Coordinator of Physical Therapy
University of Massachusetts Lowell
School of Health and Environment
Department of Physical Therapy
3 Solomont Way, Suite 5
Lowell, MA 01854-5124