

**JACKSON STATE COMMUNITY COLLEGE  
PHYSICAL THERAPIST ASSISTANT PROGRAM**

**CLINICAL TEACHING VERIFICATION FORM (CI TO COMPLETE)**

**STUDENT INFORMATION**

Student's Name: \_\_\_\_\_

Date of Clinical Experience: \_\_\_\_\_ Course Number: \_\_\_\_\_

Please Check: Summer \_\_\_\_\_ ; or Spring I \_\_\_\_\_, Spring II \_\_\_\_\_, HH \_\_\_\_\_

Upon completion of the clinical experience and the students' final evaluation please return this completed form within **THREE** business days to:

JSCC – PTA Program (Attn: Felicia Ingram or Patty Easley)

2046 North Parkway

Jackson, TN 38301

Fax: 731-425-9551

[fingram3@jsc.edu](mailto:fingram3@jsc.edu) OR [peasley@jsc.edu](mailto:peasley@jsc.edu)

**CLINICAL EDUCATION EXPERIENCE INFORMATION**

Name of Clinical Site: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ ext. \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Clinical Instructor's Name: \_\_\_\_\_

TOTAL CONTACT HOURS with Student (CI must complete): \_\_\_\_\_

Hrs/16: \_\_\_\_\_ Class II Hrs\*

Days Absent: \_\_\_\_\_, Reason: \_\_\_\_\_

Days Late: \_\_\_\_\_, Reason: \_\_\_\_\_

Were Days Made Up? Yes \_\_\_\_\_ No \_\_\_\_\_ How many? \_\_\_\_\_

Additional CI Names: \_\_\_\_\_

TOTAL CONTACT HOURS with Student (CI must complete): \_\_\_\_\_

\*CIs: FOR CONTINUING COMPETENCY EVIDENCE PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS. CONFIRMATION OF THESE HOURS WILL BE FORWARDED TO YOU FROM THE PROGRAM UPON THE RECEIPT OF THIS INFORMATION. (NOTE: 16 CONTACT HOURS WITH A STUDENT = 1 CONTACT HOUR OF CLASS II CREDIT PER THE TN BOARD OF PHYSICAL THERAPY)

Academic Faculty Verification: \_\_\_\_\_