Virginia Department of Health Professions
Board of Physical Therapy

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COMPLETION FORM FOR 320-HOUR TRAINEESHIP TO PRACTICE PHYSICAL THERAPY

TRAINEE INFORMATION

FULL NAME (First and Last)
E-MAIL ADDRESS

TRAINING FACILITY INFORMATION

FACILITY NAME	
TRAINEESHIP BEGIN DATE	TRAINEESHIP END DATE

PRIMARY SUPERVISOR INFORMATION

FULL NAME	LICENSE NUMBER
EMAIL ADDRESS OF RECORD	
EVALUATION OF TRAINEESHIP	
I hereby certify that the above-named trainee completed 320 hours of training in accordance with the Regulations Governing the Practice of Physical Therapy and was directly supervised by me. I hereby certify the information in this document is correct to the best of my knowledge.	
SIGNATURE	DATE