

FULL APPROVAL AS PHYSICAL THERAPY ASSISTANT

Note: Documentation that supports the following statements must be maintained in this candidate's file for audit purposes. The employing school district and intermediate school district retains all responsibilities related to the accuracy of this request.

Candidate's Last Name _____ First Name _____ MI _____

Birth Year: _____

ISD Name: _____ LEA Name: _____

Program Category: _____ University/College: _____

Effective Date: _____ School Year: _____

Yes No

_____ _____ 1. The candidate has completed a two-year program (or associate degree) from an accredited institution of higher education (attach documentation).

_____ _____ 2. The Intermediate School District (ISD) has received a letter of recommendation from the training institution.

_____ _____ 3. Personnel signatures by the employer and ISD.

PERSONNEL SIGNATURES:

Employing Superintendent/Designee

Date

ISD Superintendent/Designee

Date

Return to: _____
(ISD Contact) _____

Telephone #: _____

cc: Intermediate School District
School District
Candidate
University/College (if applicable)