

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 Name: Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_
ISD Name: \_\_\_\_\_ ISD Code #: \_\_\_\_\_
LEA Name: \_\_\_\_\_ LEA Code#: \_\_\_\_\_
Program Category: \_\_\_\_\_ Program Category Code #: \_\_\_\_\_
Effective Date: Month \_\_\_\_ Date \_\_\_\_ Year \_\_\_\_

- YES NO 1. The candidate has completed a two year program (or associate degree) from an accredited institution of higher education. (attach documentation).
YES NO 2. The ISD has received a letter of recommendation from the training institution.
YES NO 3. Personnel signatures by the employer and ISD.

PERSONNEL SIGNATURES:
LEA/ Employer \_\_\_\_\_ Date \_\_\_\_\_
ISD Superintendent/Designee \_\_\_\_\_ Date \_\_\_\_\_

Return To: \_\_\_\_\_
(ISD Contact) \_\_\_\_\_
Telephone #: \_\_\_\_\_

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