University of Texas Health Science Center at San Antonio
School of Physical Therapy

COST FORM FOR INTERNSHIPS

Student's Name: _____Date: _____

Facility Name: _____
(Complete Facility Name, City, & State)

Placement Within Facility (Check all that apply):

☐ Acute ☐OP Ortho ☐IP Rehab ☐OP Rehab ☐ Other (specify): _____

Dates of Internship:_____

GENERAL INFORMATION:

Describe the area of town in which the facility was located (safety, accessibility etc…):

Days worked per/wk.: _____Average Hrs. worked/wk.: _____Ave. Pt. Caseload/wk.: _____

HOUSING INFORMATION:

Housing was provided by facility: (check one) Yes ☐ No ☐ If YES (please fill in)

Type: Cost/month:

Description:

IF NO, where did you live and cost per month?

Meals Provided: YES, Free of Charge ☐ AT DISCOUNT OF: _____ NO ☐

Parking at Facility Provided: YES, Free of Charge ☐ AT COST OF: _____ NO ☐

Ave. Commute time (one way) housing ⟨ facility: _____ Mileage (one way) housing ⟨ facility: _____

Was a stipend provided? Yes: ☐ No: ☐ How much? _____ When paid? _____

EXPERIENCE INFORMATION:
(especially information you did not include on SECEE Form)

Special Learning Experiences (include clinics, conferences, home visits, co-tx, surgery observation, research, management, community service, etc.):

Things I LIKED about this experience:

Things I DISLIKED about this experience:

OVERALL ASSESSMENT:

Bad experience, Would NOT recommend ——————————————— (Draw hash mark on line) Wonderful experience, HIGHLY recommended

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