

# WAYNE STATE UNIVERSITY

EUGENE APPLEBAUM  
COLLEGE OF PHARMACY  
AND HEALTH SCIENCES

## **TRANSITIONAL PHYSICAL THERAPY CHECKLIST**

**APPLICATION DEADLINE: FALL TERM—JULY 1<sup>ST</sup>**

**WINTER TERM—NOVEMBER 1<sup>ST</sup>**

**SPRING/SUMMER TERM—MARCH 15<sup>TH</sup>**

All applicants to the Transitional Doctor of Physical Therapy Program *must* include the following supporting documentation in their application packet. Incomplete applications will not be considered for admission.

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### **Application Checklist**

- ◇ Completed application
- ◇ Official Transcripts from the University where you earned your Physical Therapy Degree
- ◇ Two letters of recommendation, utilizing the forms provided (one must be from licensed Physical Therapist)
- ◇ Personal Professional Statement
- ◇ Current resume with evidence of a minimum 1 year clinical practice
- ◇ Notarized copy of current license to practice Physical Therapy in the United States or Canada
- ◇ GRE is **NOT** required

Return tDPT program application to:  
Eugene Applebaum College of Pharmacy & Health Sciences  
Office of Student and Alumni Affairs—Attn: tDPT  
259 Mack Ave  
Suite 1600  
Detroit, MI 48201

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In addition to the above, if you are not already a current or past Wayne State University Graduate Student, you must complete the following: Wayne State University Graduate application and all documentation asked for by the Graduate Admissions, 313-577-3577 or on the web at:

<https://www.gradadmissions.wayne.edu>

**NOTE: ON THE GRADUATE SCHOOL APPLICATION, LIST YOUR MAJOR AS  
“DOCTOR OF PHYSICAL THERAPY**

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## EUGENE APPLEBAUM COLLEGE OF PHARMACY AND HEALTH SCIENCES

**Please check the box beside the program (s) you are interested in applying for.  
Please note the application deadlines:**

- ◇ Transitional Doctor of Physical Therapy—Fall term (July 1st)
- ◇ Transitional Doctor of Physical Therapy—Winter term (November 1st)
- ◇ Transitional Doctor of Physical Therapy—Spring/Summer term (March 15th)

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(Mr., Ms., Mrs.) Last Name	First	Middle
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Please list any or all other names that may appear on your academic transcripts.

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Current Address Street	City	State/Province	Zip/Postal Code
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Permanent Address Street	City	State/Province	Zip/Postal Code
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Home Telephone	Business Telephone	E-mail Address
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Wayne State ID Number	Gender (Male/Female) OPTIONAL
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Citizenship	Place of Birth	Date of Birth
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Legal Residence in City	County	State/Province	Country
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If you have an immigration visa, please specify type \_\_\_\_\_

**ETHNICITY (This section is voluntary)** Please identify your ethnic background by checking the appropriate category. Although this information is voluntary, it is used to fulfill reporting obligations of the College of Pharmacy and Allied Health Professions.

- |  |   |
|--|---|
| <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> Hispanic             |
| <input type="checkbox"/> Asian or Pacific Islander         | <input type="checkbox"/> White (not Hispanic) |
| <input type="checkbox"/> African American (not Hispanic)   | <input type="checkbox"/> Multi Racial         |
| <input type="checkbox"/> Other _____                       | (Specify)                                     |

**WAYNE STATE UNIVERSITY ADMISSION:** You must be an active Wayne State University Graduate student to be admitted to the transitional Doctor of Physical Therapy. Do you have active graduate admission status at Wayne State University?

Yes       No      If **yes**, what year did you apply? \_\_\_\_\_

When did you last take classes? Month \_\_\_\_\_ Year \_\_\_\_\_

If **no**, when do you plan to apply? Month \_\_\_\_\_ Year \_\_\_\_\_

**APPLICATION TO OTHER PROGRAMS:** Are you applying to other institutions?

Yes       No      If **yes**, which institution(s)? \_\_\_\_\_

**ACADEMIC EXCLUSION:** Have you been **excluded** from any college graduate or professional school, or denied re-admission because of deficiencies in either conduct or academic achievement?

Yes       No      If **yes**, please explain briefly on a separate page.

**LEGAL ISSUE:** Have you ever been convicted of a felony?

Yes       No      If **yes**, please explain briefly on a separate page.

**PROFESSIONAL LICENSE:** Have you ever had your **license suspended or revoked**?

Yes       No      If **yes**, please explain briefly on a separate page.

**RESUME:** Submit a current **Professional Resume** that includes work experience (with evidence of 1 year PT experience), professional development, leadership activities or positions, honors, and professional association involvement.

**POST SECONDARY (University/College) EDUCATION:** List all colleges, universities, and professional schools where a degree was received. You **must** include a copy of a transcript with your Physical Therapy degree with this application. **Wayne State University Physical Therapy graduates must supply a WSU Student Copy of their transcript.**

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Name of College/University	City and State/Province	Dates Attended	Degree
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**TOEFL:** Applicants whose **first** language is not English, must pass the **Test of English as a Foreign Language (TOEFL)** with a minimum score of **550** on the written exam, or **213** on the computer exam. Have you successfully completed the TOEFL requirement?

Yes       No  
If **yes**, list your score \_\_\_\_\_  
If **no**, what is the date of your appointment?      Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**FINANCIAL AID ASSISTANCE:** Are you receiving financial assistance?

Yes       No

If **yes**, please identify source(s).

(Include scholarships) \_\_\_\_\_

Do you anticipate applying for financial assistance?

Yes       No

If **yes**, please identify source(s).

(Include scholarships) \_\_\_\_\_

**RECOMMENDATIONS: Provide the following information regarding the persons who are providing your letters of recommendation.**

**Recommender #1 (Physical Therapist)**

<b>Name:</b>	
<b>Home Address:</b>	<b>City/State/Zip</b>
<b>Home Phone:</b>	
<b>Place of Employment:</b>	
<b>Work Address:</b>	<b>City/State/Zip</b>
<b>Work Phone:</b>	
<b>Email Address:</b>	

**Recommender #2**

<b>Name:</b>	
<b>Home Address:</b>	<b>City/State/Zip</b>
<b>Home Phone:</b>	
<b>Place of Employment:</b>	
<b>Work Address:</b>	<b>City/State/Zip</b>
<b>Work Phone:</b>	
<b>Email Address:</b>	



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### RECOMMENDATION FORM FOR TRANSITIONAL DOCTOR OF PHYSICAL THERAPY APPLICANTS

#### For Applicant Use Only

##### Applicant's Waiver Certificate:

To the Applicant: You may voluntarily waive your right to have access to a specific recommendation/evaluation written about you in accordance with Federal Family Education Rights and Privacy Act of 1974, by signing and dating this certificate. I waive, relinquish, and disclaim all my rights to have access to the recommendation/evaluation described in this form.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

#### FOR EVALUATOR USE ONLY

Please complete this application and place in a sealed envelope.

Your signature is required over the seal. The applicant will submit the sealed envelope with his/her application.

NAME OF APPLICANT \_\_\_\_\_

How long have you known applicant? \_\_\_\_\_

In what capacity do you know applicant? (please specify) \_\_\_\_\_

EVALUATED BY: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please Print Name \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_

Place of Employment \_\_\_\_\_ Phone Number \_\_\_\_\_

We encourage you to make further comments to express, clarify, and reinforce your opinions regarding this applicant's strengths and areas of concern (attach additional pages or letter if necessary)

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NAME OF APPLICANT \_\_\_\_\_

Please provide an assessment of the applicant in the following areas, comparing the applicant to others you have known in a similar capacity. The first seven items represent the core values of professionalism as identified by the American Physical Therapy Association (BOD 05-05-02-03).

	Excellent	Above Average	Average	Below Average	N/A Unable to experience to determine
<b>Accountability:</b> accepts responsibility for diverse roles, obligations, and actions of the PT, that positively influences patient/client outcomes, and the profession.					
<b>Altruism:</b> primary regard for/devotion to the interest of patients/clients and others.					
<b>Compassion/Caring:</b> desire to identify with or sense something of another's experience. Concern, empathy, and consideration for the needs and values of others.					
<b>Excellence:</b> uses current knowledge and theory while understanding personal limits; embraces advancement, and challenges mediocrity.					
<b>Integrity:</b> steadfast adherence to high ethical principles, truthfulness, and fairness.					
<b>Professional Duty:</b> provides effective physical therapy services to patients/clients, the profession, and society.					
<b>Social Responsibility:</b> promotion of a mutual trust between profession and public at large.					
<b>Communication</b>					
<b>Motivation</b>					
<b>Emotional Stability</b>					
<b>Judgment</b>					
<b>Interpersonal Relationships</b>					