



***Physical Therapy Post-Professional Clinical Residency in Orthopaedics  
Application Form***

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

States in which you hold a current PT license: \_\_\_\_\_

If not licensed, date you are scheduled to take the exam: \_\_\_\_\_

Physical Therapy Program/School where you graduated: \_\_\_\_\_

Date of graduation from Physical Therapy Program/School: \_\_\_\_\_

Date you expect to be available to enter the residency program if accepted: \_\_\_\_\_

*Please respond to the items below on separate pages. Limit your responses to no more than one page per item.*

1. State your purpose/goals for pursuing a clinical residency in orthopedic physical therapy.
2. State why you have chosen to apply to the Florida Hospital Rehabilitation and Sports Medicine Orthopedic Residency.
3. Identify your plans upon completion of the residency program.
4. Specifically explain how your experiences academically and as a practicing physical therapist or physical therapist intern/student have prepared you for this residency. Description of clinical experiences for each organization in which you performed direct patient care should include:
  - a) name, address and phone number of the facility
  - b) name of your clinical supervisor (if any) or supervisor
  - c) type of facility
  - d) job description
  - e) date employed (or dates of internship)
  - f) description of patient load
  - g) description of any clinical supervision or mentoring
  - h) time period (total hours) involved in direct patient care: total hours = (number of hours per week) x (number of weeks per year) x (number of full time years)
5. Identify any courses (continuing education courses or academic courses) you have taken to better prepare you for the residency program.
6. Attach a current resume or curriculum vitae.
7. Submit two (2) letters of recommendation. Letters must be on letterhead, addressed to the Admissions Committee. They must be from professionals who know you both professionally and personally. Also submit a prospective resident evaluation form, completed by a supervising therapist/instructor (may be one of the 2 who provides a letter of recommendation as well). The letters must be in sealed envelopes if they are sent by you as part of the application packet. Alternatively, the letter writers may send recommendations directly to the program director.
8. Review the attached policy page, sign where indicated that you have read the information provided and return with your application.

Submit this application with all attachments to:  
Laura Podschun, PT, MPT, OCS, CSCS  
Florida Hospital Sports Medicine and Rehabilitation at the RDV Sportsplex  
8701 Maitland Summit Blvd  
Orlando, FL 32810



## POST-PROFESSIONAL RESIDENCY PROGRAM IN ORTHOPEDIC PHYSICAL THERAPY

**If accepted** into Florida Hospital's Orthopedic Physical Therapy Residency Program, residents must sign a Letter of Agreement prior to beginning the residency and employment. Please verify that you have read the contents of the agreement below and return with your completed application.

### **Letter of Agreement content:**

I understand that I must fulfill the following requirements to complete the program:

- Abide by the policies and procedures of Florida Hospital
- Abide by the policies and procedures of the Physical Therapy Clinical Residency Program within the Florida Hospital system
- Successfully complete all didactic coursework taken as a part of the requirements for the residency program
- Successfully complete all clinical requirements of the residency program
- Adhere to the American Physical Therapy Association's Code of Ethics
- Adhere to the current law as it relates to the practice of physical therapy in the state of Florida

In addition, I understand the following:

- The residency position is a 12 month position as an employee of Florida Hospital
- The residency is a 40 hour per week position that requires 36 hours of patient care, Monday through Friday, with specific clinic hour's variable by center and staffing needs. The other four hours of paid time is other activities associated with the residency such as research, learning modules and teaching
- I may be dismissed from the residency if I fail to abide by the policies of Florida Hospital or the specific policies of the Residency Program
- As an employee of Florida Hospital, I am subject to the same policies regarding a 90 day probation period and all policies governing dismissal, termination and grievance for Florida Hospital employees
- I am eligible for full-time benefits and wages while employed at Florida Hospital. Benefits include malpractice coverage at no charge, and standard employee rates apply for other benefits including health, dental, life and disability insurance. Employment is granted to selected residents who fulfill all employment requirements of Florida Hospital and once licensure to practice physical therapy in the state of Florida is obtained.
- I am not eligible for continuing education benefits during the residency.
- If filling a residency position within a clinical rotation site, and I withdraw or am dismissed from the residency program, my employment at that site will be terminated. I understand that I may be

eligible for employment in an alternate Florida Hospital setting if job openings are available at that time.

- I understand that upon successful completion of the residency, I will be given preference for any openings available in the Florida Hospital orthopedic outpatient setting.
- I understand that if no openings are available in the Florida Hospital orthopedic outpatient setting, I may be offered a position in inpatient physical therapy until an outpatient position becomes available.
- I understand that during and upon completion of my residency, for a period of two years thereafter, I will not engage in the practice of Physical Therapy, as a solo practitioner, shareholder, partner, employee, or agent, at any facility or entity other than a Florida Hospital facility, or within a radius of 25 miles of any Florida Hospital facility, without the express written permission of Florida Hospital. I agree that if any restriction contained in this clause is held by any Court to be unenforceable or unreasonable, such restriction shall be severed from this agreement and a lesser restriction enforced in its place, and the remaining restrictions contained herein shall be enforceable independently of each other. In the event of a breach of this restrictive covenant, Florida Hospital shall be entitled to injunctive relief, it being agreed by the Parties to this agreement that there would be no adequate remedy at law available to Florida Hospital.

I have read the contents of the Letter of Agreement that residents accepted into the program will sign.

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Print full name

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Signature

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Date