First Lastname

Phone: (xxx) xxx-xxxx | Email: youremail@example.com | City, State Zip

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PROFESSIONAL SUMMARY

LICENSURE

EDUCATION

Degree (e.g., Doctor of Physical Therapy) — School Name, City, State
Graduation Date: Month Year

PROFESSIONAL EXPERIENCE

Job Title — Employer Name, City, State
Month Year – Month Year

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CLINICAL ROTATIONS / INTERNSHIPS

Title (e.g., Clinical Intern) — Facility Name, City, State
Month Year – Month Year

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SKILLS

CERTIFICATIONS & AFFILIATIONS