This form must be filled out by students wishing to be considered for entry into the Occupational Therapy Assistant Program and must be returned to the Admissions Office by the application deadline (February 1st, 2015)

1. NAME: ________________________________
   First          Middle          Last

2. YOUR STUDENT ID# (if known): A_________  3. DATE OF BIRTH: Month______ Day______ Year______

4. MAILING ADDRESS:
   Number and Street          City          State          Zip Code

5. TELEPHONE: ________________________________  6. E-MAIL: ________________________________
   Area Code and Number

A minimum of 15 hours of observation is required for application to the Occupational Therapy Assistant Program. The observations must occur in at least three different occupational therapy service settings (five hours in each of the major treatment areas: physical disabilities, psychiatry* and developmental disabilities/pediatrics). Please use this form to document your observations.

*If not possible to observe in a psychiatric facility, you may substitute an adult rehabilitation setting. For example, if you observed in a skilled nursing facility, you can observe in an adult outpatient or rehab facility, as a substitute for the psychiatric setting.

In a two to three page typed essay, describe your impressions and personal reactions related to the Occupational Therapy (OT) services you observed. Did you gain additional insights into the diversity and scope of the profession of occupational therapy? What were they? Why do you believe you are personally suited to this profession? Please make sure to write your age or date of birth on all submitted essays or attached documents.

<table>
<thead>
<tr>
<th>Date</th>
<th>Facility Name (where treatment area located), Address and Telephone #</th>
<th>Treatment Area</th>
<th>Hours in Attendance</th>
<th>OT Practitioner Signature</th>
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During the pre-admission observations, any information shared with students concerning patients, physicians, clinical staff, employees, or hospital business is considered confidential. Disclosure of such information to unauthorized individuals will be considered a breach of professional ethics. Your signature on this form implies that you agree to adhere to the principles of professional ethics in your interactions with patients and staff at this agency / facility.

Signature of Student ________________________________  Date ____________