Occupational Therapy Assistant Program

OBSERVATION HOURS: VERIFICATION FORM

Applicant Contact Information

Name	
Student Number	
Street Address **(city/state/zip code)**	
Phone Number	
E-Mail Address	

I hereby certify that I have completed the **40** hour observation requirement set forth by the Occupational Therapy Assistant program at Parker University.

Date ______________________ Applicant's Signature____

PLEASE NOTE: If this form is not signed by the applicant, this form will be considered not valid and will not be accepted by the OTA program.

The above-named applicant is seeking admission into our Occupational Therapy Assistant Program. He/she has indicated that they have completed observation hours at your facility. Please confirm the applicant's experience/performance by completing this form and either return to the applicant or mail to the below address**.** Thank you for your cooperation, we appreciate your time.

Parker University

2540 Walnut Hill Lane

Dallas, Texas 75229

Attn: Occupational Therapy Assistant Program

Requirements

The applicant must complete a minimum of forty (40) hours of observation experience in an Occupational Therapy setting providing direct patient/client care under the supervision of an Occupational Therapist and/or Occupational Therapy Assistant. The experience may be completed in a maximum of two (2) settings. It is essential that this requirement is fulfilled within **12 months** prior to application to the Occupational therapy Assistant program.

Throughout this observation experience, in addition to observing and participating in Occupational Therapy treatment, it is suggested that the applicant has opportunities to observe and participate in the following:

- Activities with all members of the interdisciplinary team
- Patients/clients in a variety of situations/environments
- Direct patient/care activities

Observation Experience

Applicant's association to your Facility: Volunteer ________ Employee _________

Patients/clients served by your Facility:

____

Total number of hours the applicant participated in a direct patient/care environment:

____

Dates (including year)

____

Please Rate: Quality of work: Excellent _______ Good _______ Fair_______ Poor _______

Comments: (Additional pages may be attached) ____

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Applicants receiving ratings of "Excellent" or "Good", will have fulfilled the performance criteria. If you give an applicant a "Fair" or "Poor" rating, please provide specific information indicating why that rating was given.

Facility Information

Name of Facility____

Address (Street/City/State/Zip code) ____

Name of person completing form ____

Title ____ Telephone (_______) __________________________

I affirm that the above information is accurate and the applicant has completed the stated requirements.

Signature ____ Date ________________________