OBSERVATION HOURS VERIFICATION FORM

PLEASE READ THIS STATEMENT: This form is to be completed by a licensed Occupational Therapist or a licensed Occupational Therapy Assistant. Forms completed by anyone other than an OTR/L or COTA/L will not be evaluated.

To the applicant: Please give this form to your supervising therapist. You may want to wait until you have completed as many hours of observation or work experience as possible before you have your supervisor send this form to the school. Remember that the minimum hours required is 25. Observation hours must be completed at a minimum of two different sites. You must provide an additional form for each site. The OTA program recommends that you complete the observation hours in a variety of settings. Many observation sites are requiring that you have proof of a negative TB test result and that you are CPR certified.

I. GENERAL INFORMATION: (Please print in ink)

A. Name of Applicant ______________________________

B. Dates of experience at facility ______________________

C. Number of hours spent in the Occupational Therapy Department

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D. Facility name and address ______________________________

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E. Phone number ______________________________

II. Please rate the applicant on the following behavioral characteristics:

CHARACTERISTIC	Exceptional	Excellent	Good	Below Average	Unable To Rate
Clarity of oral expression					
Interpersonal relationships/ ability to work with others					
Maturity, judgment, common sense					
Independence/ inquisitiveness					
Initiative/interest in field					
Reliability					
Motivation for proposed program of study					
Ability to accept constructive criticism					
Intellectual potential/quick to learn					
Ability to relate to clients					

*Explain items, which you rate below average and/or exceptional.

*Please indicate the level of your overall endorsement of the candidate by checking one of the categories below:

_______ Highly recommended
_______ Recommended
_______ Recommended with reservation
_______ Not recommended

Printed name of evaluator: ____

Signature: ____________________________ State & License No.:_________________________

Date: __________________________

Comments:
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PLEASE NOTE: OBSERVATION HOURS WILL NOT BE ACCEPTED IF MORE THAN TWO YEARS OLD.

APPLICANTS: Please sign the following waiver prior to giving this form to the supervising therapist.

I waive the right to review this completed form in order to afford an unbiased evaluation by the supervising therapist.

Signed:____

SUPERVISING THERAPIST, PLEASE MAIL TO:

Office of Admissions
Cabarrus College of Health Sciences
401 Medical Park Dr.
Concord, NC 28025
704-783-1556