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| **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. | | |
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| 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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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