

**LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER  
SCHOOL OF ALLIED HEALTH PROFESSIONS  
OFFICE OF STUDENT AFFAIRS**

1900 Gravier Street, New Orleans, LA 70112  
Phone: 504 568-4254 Fax: 504 568-3185 [www.lsuhscc.edu](http://www.lsuhscc.edu)

**MASTER OF OCCUPATIONAL THERAPY  
NEW ORLEANS CAMPUS**

<http://alliedhealth.lsuhscc.edu/OccupationalTherapy/>

**APPLICATION**

**APPLICATION DEADLINE: July 1<sup>st</sup>**

**APPLICATION CONTAINS:**

<b>1 - Application Instruction Sheet</b>	<b>1 – DOCUMENTATION OF EXPERIENCE FORM</b>
<b>1 – 6 PAGE APPLICATION</b>	<b>1 – PREREQUISITE DOCUMENTATION FORM (with instructions)</b>
<b>1 – TRANSCRIPT REQUEST FORM</b>	

**APPLICATION INSTRUCTIONS**

1. Please download and print a copy of this application. Indicate the requested information using a blue or black ballpoint pen or typewriter. Make a copy of the completed application for yourself, if you so desire.
2. Applications without the following will be returned: **1)** six (6) page application that is legible and complete, **2) Non-refundable \$50.00 fee payable to LSUHSC**, **3)** signature (4<sup>th</sup> and 5<sup>th</sup> pages), and **4)** prerequisite documentation form.
3. Mail all application materials to:

**Office of Student Affairs  
LSU Health Sciences Center  
School of Allied Health Professions  
1900 Gravier Street  
New Orleans, LA 70112**

4. The following must be received before the application will be considered by the Admissions Committee:  
**1)** Transcripts in Sealed and Signed Envelopes, **2)** Graduate Record Examination (GRE) scores, and  
**3)** documentation of experience form/s in Sealed and Signed Envelope.

## TRANSCRIPT REQUEST INSTRUCTIONS

Two (2) official transcripts from each college/university attended must be received in the office of Student Affairs before the application can be processed.

1. Complete the “**TO THE APPLICANT**” portion of the form.
2. Send completed form to the Registrar of each college or university you have attended. Be sure to include the required fee for each transcript. Have the Registrar send two (2) official transcripts directly to the **Office of Student Affairs, School of Allied Health Professions**, at the address given above.

## GRADUATE RECORD EXAMINATION SCORES (GRE)

Please request your official GRE scores from <http://www.gre.org/getscore.html#addscrreports>. Have your scores sent to the Office of Student Affairs, School of Allied Health Professions, at the address given above. In order for your GRE to be considered, you must have taken it within the **past five (5) years**. Our **School institution code is R6352; Department Code for Occupational Therapy is 0618**.

## DOCUMENTATION OF EXPERIENCE FORM

You are responsible for distributing and collecting the **DOCUMENTATION OF EXPERIENCE FORM** once they are completed, sealed, and signed in an envelope by an occupational therapist. The form is to be completed only by a licensed occupational therapist with who you have had 10 hours or more of clinical experience. A total of 40 hours is required for admission. You may therefore have as many as four (4) forms completed by four (4) different occupational therapists at four (4) different facilities or practice settings. You will need to:

- Complete the “**TO THE APPLICANT**” portion of the Documentation of Experience Form
- Send or deliver a form and a self-addressed stamped envelope to the occupational therapist/s that will provide documentation.
- When the Documentation of Experience form is returned to you in the sealed envelope, place it **UNOPENED** along with your other application materials.

## RETURN TO THE OFFICE OF STUDENT AFFAIRS

- Completed **Application** by the deadline
- **\$50.00** application fee
- Two (2) official **transcripts** from every university attended by the applicant if not sent directly from university
- Completed **Prerequisite Documentation form**
- Completed **Documentation of Experience** form(s)
- **GRE SCORES**

Return all the above material in a large envelope to the **Office of Student Affairs** at the above address.

- NOTE 1:** If you apply prior to completing your bachelor's degree or before completing all of the prerequisite courses, you will need to submit two (2) official copies of your transcript after completion of your degree and/or prerequisite courses.
- NOTE 2:** If you have any questions after reviewing the self-managed application, please contact the Office of Student Affairs - 504 568-4254.
- NOTE 3:** Questions regarding the occupational therapy program or special circumstances can be directed to the Interim Department Head, Jo Thompson at 504 568-4302.
- NOTE 4:** **If you are accepted into the program** you will be required to pay a non-refundable \$50.00 acceptance fee. This fee will be applied toward your first academic semester. Request for this fee will be included with the departmental letter of acceptance.



**RESIDENCY INFORMATION**

I am now and have been since \_\_\_\_\_ a residence of \_\_\_\_\_  
Date Name of State

Father's Name (if living) \_\_\_\_\_ Mother's Name (if Living) \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_  
 \_\_\_\_\_

Number Years in residence: \_\_\_\_\_ Number Years in residence: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Home Business Home Business

Employer \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_ Address: \_\_\_\_\_

For tax purposes, which person claims you as a deduction: \_\_\_\_\_ Self \_\_\_\_\_ Father \_\_\_\_\_ Mother \_\_\_\_\_ Guardian

For emergency purposes, please provide the name, address, phone number, and relationship of contact:

\_\_\_\_\_

**Resident Alien – Please Complete**

Country of Citizenship: \_\_\_\_\_

Alien registration number: \_\_\_\_\_ (enclose photocopy of both sides of card)

Date and Score of TOEFL (an overall score of 500 must be met): \_\_\_\_\_  
Month Year Score

**EDUCATIONAL INFORMATION**

List all HIGH SCHOOLS, TRADE or VOCATIONAL SCHOOLS (use separate sheet if necessary)

NAME OF SCHOOL	CITY/STATE	DATE ENTERED	DATE GRADUATED

List all COLLEGES and UNIVERSITIES you have attended. Please list in the same order attended (i.e. first attended is Number 1)

NAME	LOCATION	MAJOR	DATES ATTENDED	DEGREE CONFERRED or EXPECTED
			FROM: _____ TO: _____ Mo/Yr Mo/Yr	
			FROM: _____ TO: _____ Mo/Yr Mo/Yr	
			FROM: _____ TO: _____ Mo/Yr Mo/Yr	

Has your education to date been continuous other than for vacations? \_\_\_ Yes \_\_\_ No (if no, or if not currently attending college, please explain)

Have you previously APPLIED to the LSUHSC? \_\_\_ No \_\_\_ Yes \_\_\_\_\_

Have you previously been ENROLLED at the LSUHSC? \_\_\_ No \_\_\_ Yes \_\_\_\_\_  
discipline(s) semester(s) year(s)  
discipline(s) semester(s) year(s)

**PLEASE COMPLETE THIS BOX**

- A. Have you applied to Graduate school elsewhere? \_\_\_ No \_\_\_ Yes If yes, were you accepted? \_\_\_ No \_\_\_ yes  
 When and where did you apply? \_\_\_\_\_
- B. Have you taken the Graduate Record Exam (GRE) General Test? \_\_\_ No \_\_\_ Yes  
 Date Taken: \_\_\_\_\_ Test Results: \_\_\_\_\_ Verbal \_\_\_\_\_ Quantitative \_\_\_\_\_ Analytical \_\_\_\_\_

**SCHEDULED COURSES**

\_\_\_\_\_ I am \_\_\_\_\_ I am not – currently enrolled during the: **SUMMER semester**. If enrolled, please complete.

**Example: ABC Univ                      Engl                      1001                      Composition                      3**

COLLEGE/UNIVERSITY	DEPARTMENT CODE	COURSE NUMBER	TITLE	CREDIT HOURS

\_\_\_\_\_ I will be \_\_\_\_\_ I will not be – enrolled during the **Fall semester**. If to be enrolled, please complete.

COLLEGE/UNIVERSITY	DEPARTMENT CODE	COURSE NUMBER	TITLE	CREDIT HOURS

Please use this area if explanation is needed for any of the courses listed above: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**400 WORD ESSAY**

The Admissions Committee is interested in your reasons for wanting to enter the field of Occupational Therapy and in your ability to express the motivation behind your decision to apply.

**Please type** the answers to the following two (2) questions on page 5 of the application.

1. Describe what you have learned about occupational therapy. Emphasize what about the profession that prompted you to consider becoming an occupational therapist.
2. Describe how your personal characteristics (such as attitudes, values, behaviors), and/or life experiences, relate to your pursuit of a career in occupational therapy.

**ALL APPLICANTS – PLEASE READ AND SIGN THE FOLLOWING**  
Applications without signature will be rejected

I certify that to the best of my knowledge, the information provided on this application is correct and complete. I understand that if it is later found to be otherwise, my application will be rejected, or in the event that I am enrolled, I will be subject to dismissal from the University.

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Signature

Date

The LSU System assures equal opportunity for all qualified persons without regard to race, color, religion, sex, sexual orientation, national origin, age, disability, marital status or veteran's status in the admission to participate in or employment in programs and activities which the LSU System operates.

MASTER OF OCCUPATIONAL THERAPY APPLICATION  
400 WORD ESSAY

Please read the statement below, print and sign your name.

On my honor, I swear that the essay that I am submitting as part of the application is my original work, and my work only.

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PRINT

SIGN

DATE



Louisiana State University Health Sciences Center, New Orleans  
SCHOOL OF ALLIED HEALTH PROFESSIONS

Master of Occupational Therapy  
**ADMISSION APPLICATION ADDENDUM**

This information is required for State and Federal statistical reporting and is not used for selection purposes.

DATE: \_\_\_\_\_

Name:

\_\_\_\_\_  
LAST FIRST FULL MIDDLE NAME

SOCIAL SECURITY NUMBER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX:  Male  Female

MARITAL STATUS: \_\_\_ Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widow(er)

NUMBER OF DEPENDENTS (INCLUDE YOURSELF) \_\_\_\_\_

Are you Hispanic or Latino \_\_\_ Yes \_\_\_ No

ETHNIC ORIGIN: \_\_\_ American Indian or Alaska Native \_\_\_ Asian \_\_\_ Black or African American \_\_\_ White  
\_\_\_ Native Hawaiian or Other Pacific Islander \_\_\_ Other (specify)\_\_\_\_\_ \_\_\_ I do not wish to indicate

Veteran Status: \_\_\_ Veteran \_\_\_ Non-Veteran If you are a veteran of the U. S. Military Service are you eligible for and certified by the Veterans Administration for education benefits? \_\_\_ Yes \_\_\_ No

For Louisiana licensure purposes, have you ever been convicted, pled guilty, or are you presently charged with a crime (felony) which might be punishable by imprisonment in a penitentiary? \_\_\_ Yes \_\_\_ No

**STUDENTS WITH DISABILITIES**

If you have any questions/concerns about the Americans with Disabilities Act or specific questions about students with disabilities you may contact:

John Dolan, Rh.D. Associate Dean for Academic Affairs  
LSUHSC School Allied Health Professions  
1900 Gravier Street, New Orleans, LA 70112  
Phone: 504 568-4243 Fax: 504 568-3185  
E-mail: [jdolan@lsuhsc.edu](mailto:jdolan@lsuhsc.edu)



**LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER, NEW ORLEANS**  
**School of Allied Health Professions**  
**Department of Occupational Therapy**

**DOCUMENTATION OF EXPERIENCE: MASTER OF OCCUPATIONAL THERAPY PROGRAM**

**To the APPLICANT:** Complete items 1-5 (below) before delivering this form with a self-addressed Documentation of Experience Form Envelope to the occupational therapist who will be providing your documentation of experience. Write your name and address on the envelope. When this form has been returned to you, return the SEALED envelope with the rest of your application materials. Do not open the envelope. If the seal is broken on the envelope, your entire application will be returned to you.

Please type or print:

1. Name of applicant: \_\_\_\_\_

Current address: \_\_\_\_\_

1. Name and title of occupational therapist supplying documentation:

NAME

FACILITY

2. Date you spent at the above facility: \_\_\_\_\_

3. Total number of hours: \_\_\_\_\_

Signature of Applicant

Date

**Applicant: Do not write below this line. To be completed by only one therapist per facility.  
Please make additional copies of this form if needed for additional facilities.**

**To the OCCUPATIONAL THERAPIST:** The above named individual has applied for admission to the Master of Occupational Therapy Program at LSU Health Sciences Center in New Orleans. We require that the applicant spend a minimum of 40 hours volunteering or observing in occupational therapy under the supervision of a licensed occupational therapist(s). We need at least one (1) licensed occupational therapist (OT) and no more than four (4) OT's to independently evaluate the applicant after supervising him/her for a minimum of 10 hours.

The proper selection of applicants for our school is of significance, not only to this university but to the public as well. In order to be fair to all applicants, we need as much information as possible. We GREATLY appreciate your time and support.

This form is to be completed by one licensed occupational therapist with whom the applicant has had minimum of 10 hours of clinical experience. Only one (1) therapist per facility should complete a form for this applicant. Since a total of 40 hours is required, additional therapists from other facilities may be required to complete additional forms to accrue the 40 hours.

Please evaluate this applicant by placing an "X" on each continuum, indicating the applicant's level of performance in each area. NOTE: A mark on the far right end of the scale indicated that the applicant is Exceptional and a mark on the far left of the scale indicates that the student is Unacceptable for that particular category. Please comment if appropriate.

UNACCEPTABLE

EXCEPTIONAL

1. Responsibility: Punctual, completed tasks if asked

0            1            2            3            4            5            6            7

2. Attitude: Attentive, actively participated when appropriate

0            1            2            3            4            5            6            7

3. Communication with Staff: Initiated interactions and responded to comments and questions appropriately, demonstrated respect and sensitivity

0            1            2            3            4            5            6            7

**UNACCEPTABLE**

**EXCEPTIONAL**

4. **Communication with Patients/Clients: Initiated interactions and responded to comments and questions appropriately, demonstrated respect and sensitivity**

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
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5. **Confidentiality: Discussed patients/clients appropriately, at appropriate time and manner.**

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
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6. **Appearance: Appropriate physical and verbal presentation of self**

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
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7. **Interest in Occupational Therapy: Shared knowledge or asked questions that indicated interest in O.T.**

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
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A) 1. Describe briefly this applicant's strengths.

2. Describe briefly the qualities of this applicant that may require further development.

B) \_\_\_\_\_ 1) I recommend this applicant for admission without reservation.

\_\_\_\_\_ 2) I recommend this applicant with reservation.

\_\_\_\_\_ 3) I do not recommend this applicant for admission.

C) In signing my name below, I verify this applicant spent \_\_\_\_\_ hours under my supervision.

<b>Signature</b>	<b>Position/Title</b>	<b>OT Licensure #/State</b>	<b>Date</b>
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<b>Name (please print)</b>	<b>Facility</b>	<b>Address</b>
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Phone \_\_\_\_\_

**This form is to be returned to the applicant in the envelope provided. Please SEAL and SIGN ACROSS THE SEAL to insure confidentiality. Return the sealed signed envelope to the applicant, who will submit it unopened with the rest of his/her application. If you have any questions, feel free to contact Jo Thompson, MA, CTRS, LSU Health Sciences Center, Dept of Occupational Therapy, (504) 568-4302**

**LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER, NEW ORLEANS**  
**School of Allied Health Professions**  
**Department of Occupational Therapy**

**INSTRUCTIONS: PREREQUISITE DOCUMENTATION FORM**

**I. Prerequisite courses and prerequisite grade point average (GPA):**

- ◆ A grade of C or higher is required in all prerequisite courses.
- ◆ a course can be used only once to meet prerequisite requirements for admission.
- ◆ if a prerequisite course is not yet completed, indicate the semester in which it is or will be taken and leave the grade portion blank.

Prerequisite courses	Credits	Comments
Abnormal Psychology	3	
Anatomy/with Lab*	4 (3/1)	Human or Vertebrate or Comparative
Chemistry	3	Organic or General or Introduction or Elementary
Human Development Across Lifespan	3-6	3 credits if lifespan covered on one course; 6 credits if a separate child development course and an aging course are taken to cover the lifespan
Human Physiology*	3	Lab is highly recommended but not required
Sociology	3	Any sociology course is acceptable
Statistics	3	Must be inferential statistics; needs to include: descriptive statistics, correlation, and analysis of variance

\*If Anatomy and Human Physiology courses are taken as Anatomy & Physiology I and Anatomy & Physiology II instead of as separate courses, then a total of seven (7) credits is needed for the combined course content.

**II. Instructions: (Please see Prerequisite Documentation Form)**

1. Complete the personal data section at the top of the form.
2. For each prerequisite course, type or print: course prefix and course number; university or college where course was taken; semester/quarter that course was taken; grade received; and credit hours earned for the course.
3. Calculate the quality points for each course and enter into the designated column.

Quality points are as follows:

Grade	=	Points per credit
A	=	4
B	=	3
C	=	2
D	=	1
F	=	0

Example: An "A" grade in a 3 credit course will yield 12 quality points.

Note: Pass/Fail grades are not included in prerequisite GPA calculation.

In converting quarter to semester hours, 1 quarter hour = 2/3 semester hours, therefore, 4.5 quarter hours = 3 semester hours.

4. Calculate the prerequisite GPA and indicate it in the space provided.

**LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER, NEW ORLEANS**  
**School of Allied Health Professions**  
**Department of Occupational Therapy**

**MASTER OF OCCUPATIONAL THERAPY PROGRAM**  
**PREREQUISITE DOCUMENTATION FORM**

**Date:** \_\_\_\_\_ **SS#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Student Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Anticipated Year of Enrollment:** \_\_\_\_\_

**PREREQUISITES**

TITLE	COURSE PREFIX & #	UNIV/COLLEGE COURSE TAKEN	SEMESTER/ QUARTER COURSE TAKEN	GRADE	CREDIT HOURS	QUALITY POINTS EARNED	HOURS REQUIRED
Abnormal Psychology	_____	_____	_____	_____	_____	_____	3
Anatomy /Lab	_____	_____	_____	_____	_____	_____	3/1
Chemistry	_____	_____	_____	_____	_____	_____	3
Human Development – Lifespan	_____	_____	_____	_____	_____	_____	3
-or-							
Human Development – Child	_____	_____	_____	_____	_____	_____	3
Human Development – Aging	_____	_____	_____	_____	_____	_____	3
Physiology	_____	_____	_____	_____	_____	_____	3
Sociology	_____	_____	_____	_____	_____	_____	3
Statistics	_____	_____	_____	_____	_____	_____	3
				TOTAL =	_____	_____	22-25

**PREREQUISITE COURSES REPEATED**

_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
				TOTAL =	_____	_____	_____

**PREREQUISITE GRADE POINT AVERAGE (GPA) CALCULATION**

- (1) TOTAL OF QUALITY POINTS = \_\_\_\_\_
- (2) TOTAL OF CREDIT HOURS = \_\_\_\_\_
- (3) PREREQUISITE GRADE POINT AVERAGE =  $\frac{\text{SUM OF QUALITY POINTS}}{\text{SUM OF CREDIT HOURS}}$  = \_\_\_\_\_ GPA