Score Total

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 (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:

Name of applicant: _____

Current address (include City, State and Zip Code): _____

Name and title of occupational therapist supplying documentation:

_____

NAME **FACILITY**

Date you spent at the above facility: _____

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

Name of Applicant: _____ **Date:** _____
LAST FIRST MI

UNACCEPTABLE **EXCEPTIONAL**

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

0 1 2 3 4 5 6 7

5. Confidentiality: Discussed patients/clients appropriately, at appropriate time and manner.

0 1 2 3 4 5 6 7

6. Appearance: Appropriate physical and verbal presentation of self.

0 1 2 3 4 5 6 7

7. Interest in Occupational Therapy: Shared knowledge or asked questions that indicated interest in O.T.

0 1 2 3 4 5 6 7

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.

Signature **Position/Title** **OT Licensure #/State** **Date**

Name (please print) **Facility** **Address**

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 Kelly Alig, Ph.D., LOTR, LSU Health Sciences Center, Department of Occupational Therapy, (504) 568-4302 or kalig@lsuhsc.edu.