OCCUPATIONAL THERAPY ASSISTANT PROGRAM

DOCUMENTATION OF EXPERIENCE FORM

PLEASE PRINT. Part 1 is to be completed by the applicant. Part 2 (back of this page) is to be completed by the Occupational Therapist providing the documentation of experience.

PART 1: TO BE COMPLETED BY APPLICANT

IMPORTANT!

To the Applicant: Complete ONLY Part 1 of this form before sending it with a self-addressed stamped envelope to the occupational therapist who will be providing your documentation of experience. Write your name and address on the envelope and when it has been returned to you, enclose the SEALED envelope with the rest of your application materials. Do not open the envelope when you receive it. If the seal is broken on the envelope, your entire application will be returned to you.

1. Applicant’s Name: _______________________________________________________________________________

2. Applicant’s Current Address: _______________________________________________________________________

3. Name of Occupational Therapist supplying documentation: _________________________________________________________________________________________________

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Facility</th>
<th>Phone</th>
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4. Dates you spent at the above facility: _________________________________________________________________

5. Total hours you spent at the above facility: _____________________________________________________________

6. Circle the following that best describes the type of facility where you gained your experience.

   Acute care
   Long Term Care
   School system
   Other: 

   Rehabilitation
   Home Health
   Skilled Nursing
   Psychiatric
   Industrial Rehab

7. Circle the Types of patients you observed:

   Orthopedics
   Spinal cord
   Burns
   Other: 

   Hand Therapy
   Pediatrics
   Psychiatric
   Other: 

   Neurological (CVA, TBI)
   Amputees
   Creative Expression (art, drama, music)
   Other: 

   Geriatrics
   Cancer

8. Circle the following that describes the types of OT/treatments that you observed.

   Excercises
   Garments
   Sensory Integration
   Family consultation
   Other: 

   Positioning
   Group Activities
   Work hardening
   Splinting
   Other: 

   Recreational/games or sports
   Activities Daily Living (ADL)
   Adaptive Equipment
   Creative Expression (art, drama, music)
   Other: 

   Transfers
   Crafts
   Play
   Splinting

9. Circle the therapeutic relationship observed (ways therapist used to verbally facilitate treatment).

   Supportive
   Encouraging
   Explained
   Positive Feedback

   NONVERBAL
   Proximity
   Facial Expression
   Other: 

   Other: 

Division of Allied Health, 615 City Park Avenue, New Orleans, LA  70119  •  504-671-6201  •  FAX 504-483-4609
1. Please summarize your evaluation of this applicant by placing an “x” on each continuum indicating the applicant’s level of performance.

**Listening Skills**

- Ignores patient or OT responds inappropriately
- Attentive listener, responds appropriately

Comments:

**Verbalization**

- Painfully shy
- Hesitates to speak
- Verbalizes Well, comfortable conversing

Comments:

**Interest**

- Non-participative, Appears bored
- Shows enthusiasm, asks questions

Comments:

**Behavior**

- Nuisance, late, unreliable excessive socializing upset by patient’s conditions
- Reliable, helpful, polite courteous, pleasant to have around responds in an exceptional manner to patients

Comments:

2. Briefly describe this applicant’s major strengths and weaknesses. Use additional page if necessary.

3. Volunteer/Observer? Yes _____ No _____  Approximate Number of Hours  _____________

Paid Employee? Yes _____ No _____  Approximate Number of Hours  _____________

4. _____ I recommend this applicant for admission without reservation.

_____ I recommend this applicant for admission with reservation. Please describe.

_____ I do not recommend this applicant for admission.

Signature  Position/Title  OT License #:State  Date

Name (Please Print)  Facility  Address  Phone

This form is to be mailed 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 QUESTIONS, PLEASE CONTACT LINDA KELLY, 504-671-6241. THANK YOU FOR YOUR ASSISTANCE.