OCCUPATIONAL THERAPY PROGRAM
Department of Rehabilitation Science
School of Public Health and Health Professions
State University of New York at Buffalo
501 Stockton Kimball Tower
Buffalo, NY 14214

VOLUNTEER/WORK EXPERIENCE FORM

APPLICANT’S NAME _________________________________________ STUDENT NO. ______________________________

I hereby waive my right to inspect this form and attachments of continuation. I understand I may not be required by the institution to waive that right as a condition for admission.

Date _______________________ Student Signature _____________________________________________________________

PLEASE NOTE: If the student does not sign the statement, the law specifically reserves to the student the right of access to the letter in question.

The above-named individual, who is seeking admission to our occupational therapy program, has indicated that he/she volunteered or worked at your facility.

One criterion for admission is that an applicant must complete a minimum of seventy (70) hours of experience in an OT setting providing direct patient/client care under the supervision of an Occupational Therapist. This experience must be undertaken within two years prior to application in a maximum of two (2) settings.

During this experience we hope that the applicant has had the opportunity to observe interdisciplinary activities; observe patients/clients in a variety of situations; and participated in some direct patient/care activities.

We would appreciate your verification of the applicant’s experience by completing this form and returning it to Attn: Occupational Therapy Program, Department of Rehabilitation Science, University at Buffalo, 501 Kimball Tower, Buffalo, NY 14214-3079 by January 15th. Thank you for your cooperation.

Applicant’s relationship to your Center: Volunteer ________ Employee __________

Type of clients served by your Center : __________________________________________________________________________

Total number of hours applicant participated in a direct patient/care environment as described above: Hours _________________

Dates (including year)_____________________________________________________________________________________

*Quality of work: Excellent _______ Good _______ Fair_______ Poor _______

Comments: (Additional pages may be attached) __________________________________________________________________

Name of Center ____________________________________________________________________________________________

Address __________________________________________ No./Street __________ City/State/Zip ________________

Name of person completing form ____________________________________________________________

Title __________________________ Telephone (_______) ______________________________

Signature __________________________________________ Date ____________________________

*Please note that only ratings of “Excellent” or “Good” will receive credit toward this requirement, so if you give a “Fair” or “Poor” rating, please provide us with specific information indicating why that rating was given.

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