VOLUNTEER EXPERIENCE FORM

APPLICANT’S NAME ____________________________________________________________

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 ______________________________________________________________________

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 is seeking admission to our occupational therapy program.

One criterion for admission is that an applicant must complete a **minimum of seventy (70) hours** of observational/volunteer experience in a United States OT setting, at a site that provides direct patient/client care. The student must be supervised by a **licensed Occupational Therapist**. 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, if permitted, **participate** in some direct patient/care activities. This experience must be undertaken within two years prior to application in a maximum of two (2) settings.

Remit the completed form to: Occupational Therapy Program, Department of Rehabilitation Science, University at Buffalo, 501 Kimball Tower, Buffalo, NY 14214-3079 by **January 15**th. Thank you for your cooperation.

Types of clients served by your Center: ______________________________________________________

**Total number of hours applicant participated in the volunteer experience as described above:** __________________________

Dates volunteered (please include year): ______________________________________________________

**Quality of volunteer work**

Please provide information on the overall quality of volunteer work provided by this applicant. Please consider such things as timeliness, appropriate appearance, adherence to rules/regulations, ability to interact with therapists and staff, ability to interact with service recipients, general conduct, and professionalism.

*Overall, this volunteer demonstrated work that was:   Excellent___ Good___ Fair___ Poor___*

Please provide any comments/examples here. You may attach additional pages if desired. _______________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Name of Center: __________________________________________________________

Address: ________________________________________________________________________________

Supervising Occupational Therapist Name (OTR/L): _________________________________

**Title:** ___________________________________________________ Phone (Incl area code): __________________ Date Signed: __________________

Signature: ___________________________________________ Email: _______________________________

*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.

July 2017