VOLUNTEER EXPERIENCE FORM

APPLICANT’S NAME (PRINT) _____________________________________ APPLICANT EMAIL ______________________________

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 _______________________  Applicant 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 **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 15th**. 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): _____________________________________________________________

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**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: ___________________________ No./Street ____________________________________________________________________________ City/State/Zip

Supervising Occupational Therapist Name (OTR or 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.

November 2017