



OBSERVATION 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.

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The above-named individual is seeking admission to our athletic training program.

One criterion for admission is that an applicant must complete a **minimum of ten (10) hours** of observational/volunteer experience in an athletic training setting, at a site that provides direct patient/client care. The student must be supervised by a **licensed and Certified Athletic Trainer**. 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.

Remit the completed form to: Athletic Training Program, Department Exercise & Nutrition Sciences, University at Buffalo, 207 Kimball Tower, Buffalo, NY 14214-3079 or e-mail to ryankrzy@buffalo.edu or fax to 716.829.2428. Thank you for your cooperation.

Types of Patients served by your Facility: _____

Total number of hours applicant participated in the observation experience as described above: _____

Dates observed (please include year): _____

Quality of observation work

Please provide information on the overall quality of observation 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 Facility: _____

Address: _____
No./Street City/State/Zip

Supervising Athletic Trainers' Name: _____

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.