

UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
DEPARTMENT OF OCCUPATIONAL THERAPY
DOCUMENTATION OF OCCUPATIONAL THERAPY OBSERVATION -OTD

Applicant Name _____ Application Number: _____

Requirement: A minimum of 24 documented observation hours from at least three occupational therapy clinical departments or practices within two calendar years preceding the application deadline. This form may be duplicated for use at each observation site.

Applicant: Provide an addressed and stamped envelope to the OTR/OTA supervisor with the following address:
OTD Admissions Counselor, University of Mississippi Medical Center, Office of Student Records and Registrar, 2500 North State Street, Jackson, MS 39216 Fax: 601.984.1079 ATTN: OTD Admissions Counselor Email: fbroderick@umc.edu

OTR/OTA Supervisor: Place the completed form in the envelope, seal it and sign across the back. Applicant may mail the form as long as the signature remains intact. Supervisors may prefer to either fax **OR** to scan and email the form directly the OTD Admissions Counselor at the contact, above. **For questions or concerns, contact the SHRP OTD Department at 601.984.6350.**

DOCUMENTATION OF OBSERVATION HOURS:

Date of Observation	# Hours Observed in Setting	Setting (i.e., Acute, Inpatient, Peds, Schools, SNF, Home Health, Rehab, etc.):
TOTAL OF HOURS:		

Is this student employed or completing an internship at this *facility*? Yes No
Is the student employed or completing an internship in this *setting*? Yes No

Rate the Student on the following (0 = not at all; 4 = very much so; N/O = not observed)

The Student:	0	1	2	3	4	N/O
Is punctual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dresses professionally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exhibits professional behavior & attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Demonstrates positive communication with patients/team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is appropriately active, interested and engaged	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional COMMENTS that may be useful during the OTD application process:

Facility name & address: _____

Supervisor name & credentials: _____ LICENSE # _____

Supervisor's Email/Phone: _____

Supervisor Signature: _____ Date _____