CABARRUS COLLEGE of HEALTH SCIENCES

OBSERVATION HOURS VERIFICATION FORM

The Observation Hours Verification form must be completed by a licensed Occupational Therapist (OT/L) or Occupational Therapy Assistant (OTA/L). Forms completed by anyone other than on OTR/L or COTA/L will not be evaluated. A total of at least 25 observation hours in a minimum of three different settings are required for application to the OTA Program. Many observation sites require that you have proof of CPR and TB test results.

Applicant shall provide each site with the following:

- The Observation Hours Verification form with the top section completed and signed by the applicant.
- A stamped envelope addressed to Cabarrus College of Health Sciences, 401 Medical Park Drive, Concord, NC 28025 c/o Admissions Office

GENERAL INFORMATION (Please print in ink)

Name of Applicant: _____ Facility Name: _____

Dates of Experience at Facility: _____ Number of Hours spent in the Occupational Therapy Dept._____

APPLICANTS: Please sign the wavier below prior to giving this form to the supervising therapist.

I waive the right to review this completed form in order to afford an unbiased evaluation by the supervising therapist.

Applicant Signature: _____ Date: _____

To the supervising OT/OTA, please rate the applicant on the following characteristics and return the form to the College in the stamped and addressed envelope provided by the applicant.

CHARACTERISTIC	Exceptional	Excellent	Good	Below Average	Unable to Rate
Clarity of oral expression					
Interpersonal relationships/ability to work with others					
Maturity, judgment, common sense					
Independence/Inquisitiveness					
Initiative/Interest in the field					
Reliability					
Motivation for proposed program of study					
Ability to accept constructive criticism					
Intellectual potential/Quick to learn					
Ability to relate to clients					

*Explain items that you rate below average and/or exceptional.

_____

*Please indicate the level of your overall endorsement for admission of the candidate by checking one of the categories below:

☐ Highly Recommend ☐ Recommend ☐ Recommend with Reservation ☐ Does Not Recommend

_____ _____

Printed Name of Evaluator State & License Number

_____

Evaluator Signature Date

COMMENTS: _____

_____

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OBSERVATION HOURS WILL NOT BE ACCEPTED IF MORE THAN TWO YEARS OLD.

SUPERVISING THERAPIST, PLEASE MAIL TO:
Office of Admissions, Cabarrus College of Health Sciences
401 Medical Park Drive
Concord, NC 28025
704-403-1555 or 1556 - Fax 704-403-2077