ROANE STATE COMMUNITY COLLEGE
Occupational Therapy Assistant Program Recommendation Form

Part 1. TO BE COMPLETED BY APPLICANT

Name (print) _____

R# _____

Check **one** of the following two options:

_____ I waive the right to review this confidential recommendation form when it becomes a part of my permanent file at Roane State Community College. I understand that this waive is optional under the Family Education Rights and Privacy Act of 1974.

_____ I do not waive the right to review this confidential recommendation form.

Signature _____ Date _____

Part 2. DIRECTIONS TO SUPERVISOR OF APPLICANT

The individual named above is seeking admission to the Occupational Therapy Assistant Program at Roane State Community College. **Applicants are required to observe occupational therapy services in two different practice areas for a minimum of 8 hours in each setting.** The information you provide will assist the Admissions Committee in determining this individual's qualifications and potential for success in the OTA program. Comments will be held confidential if the named individual has waived their right to review the recommendation.

Supervisors completing this form must be an OT or OTA with a **minimum of one year of experience** and should not be related to the applicant.

Part 3. INSTRUCTIONS FOR SUBMISSION OF RECOMMENDATION FORMS

- Scan both pages of the form
- Send the scanned document to hsnadmissions@roanestate.edu
- Subject line must include the words **"OTA Recommendation" and the first and last name of the applicant**

Notes:

- Do **not** fax, mail, or hand-deliver recommendation forms
- Incomplete forms or forms received after the application deadline will not be considered
- Please do not submit more than two recommendation forms

TO BE COMPLETED BY SUPERVISING THERAPIST

First and last name of applicant _____

Name of facility _____

Address of facility _____

Supervisors name _____ Years experience? _____

I am an (check one) ____OT ____ OTA

May we contact you if we need clarification? _____ yes _____ no

Supervisor's preferred method of contact:

Email address _____

Phone _____

_____ Total hours applicant observed or volunteered at facility

I certify that I am not related to the applicant (please initial) _____

Please indicate if the following behaviors were clinically acceptable (A) or need improvement (N).

_____The applicant demonstrated good time management skills as evidenced by making request for observation hours with appropriate amount of advanced notice, arrived promptly on designated date(s), remained through duration of scheduled observation.

_____The applicant demonstrated appropriate dress and professional demeanor, including emotional maturity, during observations.

_____The applicant demonstrated good interpersonal skills during interactions with supervisor, patients/clients and others in the facility as evidenced by body language, eye contact, listening skills, and ability to verbalize thoughts in clear manner.

_____The applicant appeared to have a basic understanding of occupational therapy services, asked relevant questions and demonstrated reasoning and insight.

Please summarize your overall recommendation by checking one of the following:

_____ Strongly recommend

_____ Recommend

_____ Recommend with reservations (explain) _____

_____ Do not recommend (explain) _____