

FORM: OTA Observation 1
NAME:
Student ID:
DOB:

(internal use only)

Central Community College
Occupational Therapy Assistant Program Application
Verification of OT Observation Hours (practice setting 1)

WAIVER OPTION

The Family Education Rights and Privacy Act of 1974 states that student records are available for inspection by the student. The law also permits the student to sign a waiver relinquishing his or her right to inspect letters of recommendation. The applicant's signature below constitutes a waiver; no signature means the student will have the right to read this reference.

Applicant's Printed Name _____ Date _____

This is to verify that _____ has completed _____ hours of
observation at _____. Dates completed _____

Practice Setting Observed: _____

This student is applying for admission to the Central Community College Occupational Therapy Assistant Program. Please comment on this student's motivation for the profession and potential as a future occupational therapy practitioner

Please comment on any concerns you may have regarding this student:

Name _____ Position Title _____

Signature _____ Date _____ Phone Number _____

Please return completed form to:

Central Community College
Occupational Therapy Assistant Program
3134 West Highway 34
P.O. Box 4903
Grand Island, Nebraska 68802-4903

The Observation Hours Form is to be completed by the OTR or COTA and returned to Central Community College

FORM: OTA Observation 2

NAME:

Student ID:

DOB:

(internal use only)

Central Community College
Occupational Therapy Assistant Program Application
Verification of OT Observation Hours (practice setting 2)

WAIVER OPTION

The Family Education Rights and Privacy Act of 1974 states that student records are available for inspection by the student. The law also permits the student to sign a waiver relinquishing his or her right to inspect letters of recommendation. The applicant's signature below constitutes a waiver; no signature means the student will have the right to read this reference.

Applicant's Printed Name _____ Date _____

This is to verify that _____ has completed _____ hours of
observation at _____. Dates completed _____

Practice Setting Observed: _____

This student is applying for admission to the Central Community College Occupational Therapy Assistant Program. Please comment on this student's motivation for the profession and potential as a future occupational therapy practitioner

Please comment on any concerns you may have regarding this student:

Name _____ Position Title _____

Signature _____ Date _____ Phone Number _____

Please return completed form to:

Central Community College
Occupational Therapy Assistant Program
3134 West Highway 34
P.O. Box 4903
Grand Island, Nebraska 68802-4903

**The Observation Hours Form is to be completed by the OTR or COTA and returned to Central
Community College**