# Occupational Therapy Assistant Observation Form #1

*To be completed by Student Applicant*

Student Applicant Name (print) _____ Student ID (R#) _____

Phone Number _____ Email _____

**To be completed by Licensed OT or OTA Evaluator:** Thank you for your time in introducing this applicant to the Occupational Therapy profession. The student is required to observe an OT or OTA. Upon completion of the students time in your facility, please complete the form below to verify hours in the facility and professional characteristics. Your ratings and comments provide valuable feedback for continued professional development. We appreciate your candid opinion.

Observation Dates: _____/_____/_____ to _____/_____/_____ TOTAL HOURS: _____

| Characteristic | Poor | Fair | Good |
|---|---|---|---|
| **Personal appearance** | Sloppy, too casual, and/or too revealing **1** | One clothing item inappropriate **2** | Complies with dress code **3** |
| **Attitude toward patients** | Rude, careless, or disrespectful **1** | Indifferent or overly chatty **2** | Pleasant and appropriate **3** |
| **Attitude toward staff** | Rude or sullen **1** | Indifferent or overly friendly **2** | Cooperative and respectful **3** |
| **Communication skills** | Poor listener, no attempts to ask questions and/or talks about self only **1** | Unclear questions or random attempts **2** | Thoughtful questions that are on topic **3** |
| **Motivation** | Disinterested in patient care **1** | Occasional interest in therapy process **2** | Seeks out learning in appropriate ways **3** |

Rate your overall endorsement of the applicant as a future colleague (Select one):

❑ Highly recommended ❑ Recommended ❑ Recommended with reservation ❑ Not recommended

Evaluating Therapist Name (print) _____ Date_____/_____/_____

Evaluator's Phone Number if verification is required _____

Name of Facility _____ *(Check type of setting below)*

❑ Inpatient *(IE: Hospital)* ❑ Skilled Nursing Facility *(IE: Nursing Home)* ❑ Outpatient *(IE: Outpatient Clinic, Hand Clinic)* ❑ Pediatrics *(IE: Schools, Hospital Unit, Outpatient)* ❑ Other *(IE:Home Health, Menta Health)*

Signature_____ License #_____

**Please give completed form to the student for submission. If desired, form may be placed in a sealed envelope. Please sign over the seal of the envelope.**

Occupational Therapy Assistant Program
Rhodes State College
4240 Campus Drive, TEL 102H
Lima, Ohio 45804
FAX (419) 995-8093

| For office use only | |
|---|---|
| Program Director signature /date | |
| Banner entry and date | |

# Occupational Therapy Assistant Observation Form #2

*To be completed by Student Applicant*

Student Applicant Name (print) _____ Student ID (R#) _____

Phone Number _____ Email _____

**To be completed by Licensed OT or OTA Evaluator:** Thank you for your time in introducing this applicant to the Occupational Therapy profession. The student is required to observe an OT or OTA. Upon completion of the students time in your facility, please complete the form below to verify hours in the facility and professional characteristics. Your ratings and comments provide valuable feedback for continued professional development. We appreciate your candid opinion.

Observation Dates: _____/_____/_____ to _____/_____/_____ TOTAL HOURS: _____

| Characteristic | Poor | Fair | Good |
|---|---|---|---|
| **Personal appearance** | Sloppy, too casual, and/or too revealing **1** | One clothing item inappropriate **2** | Complies with dress code **3** |
| **Attitude toward patients** | Rude, careless, or disrespectful **1** | Indifferent or overly chatty **2** | Pleasant and appropriate **3** |
| **Attitude toward staff** | Rude or sullen **1** | Indifferent or overly friendly **2** | Cooperative and respectful **3** |
| **Communication skills** | Poor listener, no attempts to ask questions and/or talks about self only **1** | Unclear questions or random attempts **2** | Thoughtful questions that are on topic **3** |
| **Motivation** | Disinterested in patient care **1** | Occasional interest in therapy process **2** | Seeks out learning in appropriate ways **3** |

Rate your overall endorsement of the applicant as a future colleague (Select one):

❑ Highly recommended ❑ Recommended ❑ Recommended with reservation ❑ Not recommended

Evaluating Therapist Name (print) _____ Date_____/_____/_____

Evaluator's Phone Number if verification is required _____

Name of Facility _____ *(Check type of setting below)*

❑ Inpatient *(IE: Hospital)* ❑ Skilled Nursing Facility *(IE: Nursing Home)* ❑ Outpatient *(IE: Outpatient Clinic, Hand Clinic)* ❑ Pediatrics *(IE: Schools, Hospital Unit, Outpatient)* ❑ Other *(IE:Home Health, Menta Health)*

Signature_____ License #_____

**Please give completed form to the student for submission. If desired, form may be placed in a sealed envelope. Please sign over the seal of the envelope.**

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