

OCCUPATIONAL THERAPY PROGRAM

Please read all the information below before completing the application for the Occupational Therapy Program. The application deadline is February 15. Early review is November 15. Please contact our office after deadline date. Admissions will remain open until all classes are filled. Priority will be given to applications returned by the due date.

IT IS THE APPLICANT'S RESPONSIBILITY TO PROVIDE THE FOLLOWING DOCUMENTATION.

A. Occupational Therapy Program Admission Application:

1. Indicate any name(s) that you have previously used, such as a maiden name.
2. Submit a credit card, check, or money order for \$75.00 payable to Seton Hall University, to cover the application fee, to:

Seton Hall University
Attn: Deborah Verderosa - Occupational Therapy Program
School of Graduate Medical Education
400 South Orange Avenue, South Orange, NJ 07079

3. **NOTE:** Following an initial screening of applications, candidates being considered for admission will be contacted by mail.

B. Applicant Essay/ Questionnaire:

Essay must not exceed 3 typed pages.

C. Official transcripts from all colleges, universities and/or professional schools attended (including other occupational therapy programs), even if you attended for less than one full semester.

1. Official Transcripts must be sealed and submitted with your application materials.
2. All transcripts from outside the United States (including college and high school) must be evaluated course by course by a recognized transcript evaluation agency. Translations alone will not be accepted. We recommend:

World Education Services
PO Box 745
Old Chelsea Station
New York, NY 10113-0745
Tel. No.: 212-966-6311 FAX: 212-966-6395

- D. **One** letter of recommendation must be from an Occupational Therapist who supervised your clinical observation. (At least 50 hours clinical observation is required.) Verification of hours must be submitted with application.

- E. If your degree is from a school in a non-English speaking country, please provide a copy of Test English as a Foreign Language (TOEFL) scores.

For more information, please go to: Gradmeded.shu.edu/graduateprograms/msot.html

<p>NOTE: The candidate must submit all application materials online before March 15. TOEFL scores must be received by this date. Priority will be given to all applications received by March 15; however, admissions will remain open until the class is filled.</p>
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School of Graduate Medical Education

This is a full-time entry level professional program.

Term of entry: _____

Have you previously applied for admission? Yes No If yes, what year? _____

Title Mr. Ms. Sr. Dr. Other

Name _____
Last Name First Name Middle

Other names your records may be under

Social Security Number _____ **Gender** Male Female

Date of Birth ____/____/____ **Place of Birth** _____
Month/Day/Year

Marital Status (optional) : _____ **Ethnic Background (optional)** : _____

Religious Affiliation (optional) : _____

Mailing Address _____ **Address valid until:** ____/____/____
Number and Street Month/Year

City State/Province Zip + suffix

Country

Permanent Address

Number and Street

City State/Province Zip + suffix

Country

Email _____

Type _____

Telephone and Fax Numbers

Current Home Telephone

Work Telephone

(May we contact you here?) Yes No

Fax Number

(May we contact you here?) Yes No

() _____
Country / Area Code / Number

() _____
Country / Area Code / Number

() _____
Country / Area Code / Number

Mobile Phone

(May we contact you here?) Yes No

() _____
Country / Area Code / Number

Citizenship

Country(ies) of Citizenship: _____ **Visa Type:** _____

Non - U.S. citizens only: Are you a U.S. permanent resident? Yes No

Testing Information

TOEFL (for international applicants only)

Date taken (or plan to take) ____/____/____ Section 1 _____ Section 2 _____ Section 3 _____ Total _____
Month/Year Score Score Score Score

To which other graduate schools have you applied?

Education

Undergraduate Grade Point Average (if available) _____

Please list all post-secondary colleges, universities, or institutions attended, including those attended for summer session or evening classes. OFFICIAL transcripts from all colleges and universities attended including those attended for less than one full semester/quarter must be provided.

Name of school	Dates attended	Degree received	Major field	CEEB
	/ - /			
	/ - /			
	/ - /			
	/ - /			
	/ - /			

References

Please list your evaluators.
(One reference must be from a certified occupational therapist, registered (OTR).)

1. Name _____ Relationship to applicant _____
 Mailing Address _____
 Phone Number _____ () _____ E-mail _____

2. Name _____ Relationship to applicant _____
 Mailing Address _____
 Phone Number _____ () _____ E-mail _____

3. Name _____ Relationship to applicant _____
 Mailing Address _____
 Phone Number _____ () _____ E-mail _____

Source(s) of Information

How did you learn about the Program? _____

Employment History

Beginning with your most recent job, please list below in reverse chronological order each of the jobs you have had since the beginning of your college studies. **Please account for all periods of time.** You may use the "Additional Information" page if necessary.

Employer _____ From _____ (month/year) / _____ To _____ (month/year) / _____ or Current
 Employer Nature of Business _____ Position/Job Title: _____
 Location _____

Employer _____ From _____ (month/year) / _____ To _____ (month/year) / _____ or Current
 Employer Nature of Business _____ Position/Job Title: _____
 Location _____

Employer _____ From _____ (month/year) / _____ To _____ (month/year) / _____
 Employer Nature of Business _____ Position/Job Title: _____
 Location _____

Volunteer Experience

Fifty (50) hours of OTR supervised activity is required. Indicate where you have volunteered under the supervision of an OTR. Use the "Additional Information" (page 5) if necessary.

1. Name _____ Number of Hours _____
 Location _____

2. Name _____ Number of Hours _____
 Location _____

3. Name _____ Number of Hours _____
 Location _____

Submit Verification Paperwork by mail

Prerequisites Please provide the following information concerning each of the prerequisites you have taken.

	Institution	Semester/Year	Final Grade
Anatomy and Physiology I		/	
Anatomy and Physiology II		/	
English		/	
Gen. Psych.		/	
Abnormal Psych.		/	
Sociology / Anthropology		/	
Dev. Psych.		/	
Statistics		/	

ADDITIONAL INFORMATION

Transcript Request

Please forward an official copy of my academic transcript to:

Seton Hall University
School of Graduate Medical Education
Attn: Deborah Verderosa
400 South Orange Avenue
South Orange, NJ 07079

Name

Last

First

M.I.

Address

Number

Street

City

State

Zip

Telephone (Day) _____ (Evening) _____

Social Security Number _____ - _____ - _____

Date of Birth

Month

Day

Year

Thank you for your attention to my request. Please advise me of any fee for this service.

Signature

Date

OCCUPATIONAL THERAPY PROGRAM RECOMMENDATION

Applicant _____ SS# _____
LAST FIRST MI

RECOMMENDATIONS FROM FRIENDS, FAMILY MEMBERS, OR ACQUAINTANCES ARE NOT ACCEPTABLE.

To the Applicant:

Complete the top portion of the form and give it to the person making the recommendation.

Right to Access:

This letter of recommendation is confidential. Such letters are not accessible to applicants for admission. However, Public Law 93-380, Educational Amendments Act of 1974, grants enrolled students the right to inspect letters of recommendation. If the applicant does not waive the right to access and is admitted and enrolled, he or she will be able to access these letters.

Please check one: *I* **do**, **do not waive** right to access this letter.

SIGNATURE OF APPLICANT

DATE

To the Recommender:

Complete questions 1 through 5; your signature is required on the second page of this form. There is space provided on the second page to provide additional information and/or comments about the applicant that could be considered relevant to his/her admission to our program.

1. In what capacity have you known the applicant? _____

2. How long have you known the applicant? _____

3. Place a check mark next to the response that best indicates your opinion if you were in a position to employ the applicant:

- | | |
|---|---|
| <input type="checkbox"/> employ eagerly | <input type="checkbox"/> employ with reluctance |
| <input type="checkbox"/> employ with satisfaction | <input type="checkbox"/> would not consider employing |

4. Place a check mark next to the response that best represents your opinion if you were in a position to decide whether the applicant should be accepted for a program of study leading to a health care profession:

- | | |
|--|--|
| <input type="checkbox"/> definitely accept | <input type="checkbox"/> probably reject |
| <input type="checkbox"/> probably accept | <input type="checkbox"/> definitely reject |



**School of Graduate Medical Education
Observation Hours Verification Form for OT program**

Make additional copies of this form as needed.

This is to verify that _____ has completed _____
(Name)

observation hours with me at _____.
(Name of facility)

Name and credentials (please print)

Signature

Date