Clinical Rotation Application

Occupational Therapy Students

Last Name: _____ First Name: _____ MI: _____

Email: _____ Phone #: _____

School: _____ Program: _____

Faculty Contact: _____ Email: _____

Affiliation: ☐ Level 1 ☐ Level 2 Anticipated Graduation Date: _____

Is student a current or former Kadlec or Providence employee or student? ☐ Yes ☐ No Department: _____

Has student participated in another Kadlec student program? ☐ Yes ☐ No Program: _____

Desired Rotation(s):

☐ Inpatient ☐ Outpatient ☐ Pediatrics ☐ Adults

☐ Acute ☐ Inpatient Rehabilitation ☐ Physical Disabilities

Desired Date(s) for Placement: _____

Number and Type of Affiliations completed prior to requested placement: _____

Please list student's strengths and areas of growth noted in course work: