

**Occupational Therapist Eligibility Determination (OTED)
Program Director Form**

OTED Applicant: Please complete this section only.

First Name: Middle: Last:

Any previous name(s) used:

I authorize the college/university completing this form to provide the National Board for Certification in Occupational Therapy, Inc. (NBCOT®) with all the information/documentation requested, both favorable and unfavorable.

Signature:

Date:

Program Director: The above named person is applying for eligibility to take the NBCOT Certification Examination for OCCUPATIONAL THERAPIST REGISTERED OTR®. Please complete this form, include an official stamp or seal, and mail to NBCOT (see address below).

Program: Occupational Therapy Program

Department:

College/University:

Address:

City:

State/Province:

Country:

Postal Code:

Phone (with country and city/area codes):

Fax (with country and city/area codes):

E-mail:

Clinical/Fieldwork Experience: The following grid does not need to be completed for US and Canadian programs.

Number of Hours		Patients/Clients Treated: Please describe the type of experience (physical disabilities, pediatrics, mental health, etc.)
hrs	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	
hrs	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	
hrs	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	

Has the applicant completed clinical/fieldwork under the supervision of a qualified occupational therapist? Yes No
If no, please explain on reverse side of this form.

Total Number of clinical/fieldwork hours/weeks:

Date of completion:

At the time of the applicant's graduation, the OT program was approved by one of the following: (Check One)

US Occupational Therapy Programs

The Accreditation Council for Occupational Therapy Education (ACOTE), **OR**

International Occupational Therapy Programs

National governmental institution that approves/accredits occupational therapy programs that grant a degree in occupational therapy (e.g. Ministry of Health), **AND/OR**

The World Federation of Occupational Therapists (WFOT)

Official Stamp/Seal

Please sign: I hereby attest that my responses are complete and accurate to the best of my knowledge.

Signature of Program Director:

Date:

Print Name: