

# P=OTD APPLICATION FORM

# Please print.

College of Applied Health Sciences Department of Occupational Therapy 1919 West Taylor St., M/C 811

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(312) 413-0256 (Fax)

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[**www.ahs.uic.edu/ot**](http://www.ahs.uic.edu/ot)

* Mr.
* Ms.

Last Name or Surname First or Given name Middle or Maiden E-mail Address

# Mailing Address

Street City State Zip Code

**Telephone** Second number where you can be reached:

Area Code + Phone Number Area Code + Phone Number

**Permanent Address (if different)**

Street City State Zip Code

**Date of Birth Gender:** □ Male □ Female **Illinois resident:** □ Yes □ No

**OT Certification Status**

I am a certified occupational therapist.

Please enclose a copy of your certificate from the National Board for Certification in Occupational Therapy and your state occupational therapy license, if applicable.

I am not certified as an occupational therapist, but am eligible for certification as I have graduated from a program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) or approved by the World Federation of Occupational Therapy.

# I understand that my application will be considered only if all materials are submitted and my official examination scores are received. I accept responsibility to include all of the required materials when I submit my application. I have read the instructions for completing this application and I certify that the all statements are correct and complete.

**Signature**

**Faculty Advisor**

Applicants who are accepted into the OTD program will be matched with one of the UIC OT faculty members (see OTD Application Instructions for details). This faculty member will act as the student’s academic advisor and mentor throughout the OTD program.

I, (faculty name), have talked with (applicant name) and am interested and willing to supervise him/her if he/she is admitted to the OTD program.

Signature Date

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Signature Date