# Request for Observation Program

Please complete the following and include a copy of your **resume** as well as a brief description of why this experience is important to you and include any factors leading up to your decision to apply with us.

**Name:** ___________________________ **Email Address:** ___________________________

**Phone Number** (best to reach you during business hours):

________________________________

**Profession you wish to observe (please circle):**

Physical Therapist    Occupational Therapist    Speech Therapist

**Setting you wish to observe** (please circle): Clinic Adults    Clinic Pediatrics    School

**Total hours of observation needed:** ___________

**Deadline to complete your observation by:** ___________________________

**Your specific availability** (days and times):

| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|---|---|---|---|---|---|
| | | | | | |

**Your preferred choice of location** (number 1-3)**:**
Fairfield____    Milford____    Shelton___
Stratford____    Westport____

**Please return completed form via US Postal Service to you preferred location attn: clinical supervisor.**