

Request for Observation Program

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

*Applications will not be processed without receiving all above mentioned paperwork.

Name: _____ **Email Address:** _____

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

Profession you wish to observe (please circle):

Physical Therapy Occupational Therapy Speech Therapy

Setting you wish to observe (please circle): Clinic Adults Clinic Pediatric School Early Intervention

Your specific availability (days and times):

Monday	Tuesday	Wednesday	Thursday	Friday

Your preferred choice of location (Number 1-3):

Fairfield__ Milford__ Shelton__

Stratford__ Westport__

Please return completed form, resume and letter of intent via US Postal Service to:

Rehabilitation Associates Inc.

Attn: Student Observation Coordinator

1931 Black Rock Turnpike

Fairfield CT, 06825