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 Early Intervention

Total number of observation hours you are requesting. Please indicate if you would like hours in more than one area and if so, where and how many.

_____

Date ranges that you are requesting: _____

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