BROOKS IHL OCCUPATIONAL THERAPY NEUROLOGIC RESIDENCY APPLICATION 2017-2018

In addition to full **typed** completion of the information requested below, please include the following:

- *Resume/CV*
- *Copy of Professional License/Certification*

PAGE 9, REFERENCES INFORMATION, ARE **DUE ONE WEEK PRIOR TO APPLICATION DEADLINE.**

PLEASE SUBMIT ALL MATERIALS TO MCKENZIE KELLY NO LATER THAN **FEBRUARY 21, 2017 @ 11:59PM:**

3599 University Blvd South
Jacksonville, FL 32216
McKenzie.Kelly@Brooksrehab.org
O: 904.345.7061
F: 904.345.7193

PERSONAL DATA

Last Name	First Name
Street Address	City/State/Zip
Primary Phone Number	Primary E-Mail

COLLEGES ATTENDED

Name	Years Attended From-To
Degree Earned	Degree Awarded Date
Name	Years Attended From-To
Degree Earned	Degree Awarded Date
Name	Years Attended From-To
Degree Earned	Degree Awarded Date

Name	Years Attended From-To
Degree Earned	Degree Awarded Date

CONTINUING EDUCATION COURSES

Name	Organization	Date Completed
Name	Organization	Date Completed
Name	Organization	Date Completed
Name	Organization	Date Completed
Name	Organization	Date Completed
Name	Organization	Date Completed
Name	Organization	Date Completed

EXPERIENCES

PROFESSIONAL EMPLOYMENT HISTORY

Position Title	Organization Name	Dates
City, State	Average Hours per Week	Name of Supervisor
May we Contact this Organization	Supervisors E-Mail Address	Supervisors Phone Number

Duties:

Position Title	Organization Name	Dates
City, State	Average Hours per Week	Name of Supervisor
May we Contact this Organization	Supervisors E-Mail Address	Supervisors Phone Number

Duties:

Position Title	Organization Name	Dates
City, State	Average Hours per Week	Name of Supervisor
May we Contact this Organization	Supervisors E-Mail Address	Supervisors Phone Number

Duties:

CLINICAL EXPERIENCES/INTERNSHIPS

Position Title	Organization Name	Dates
City, State	Average Hours per Week	Name of Supervisor
May we Contact this Organization	Supervisors E-Mail Address	Supervisors Phone Number

Duties:

Position Title	Organization Name	Dates
City, State	Average Hours per Week	Name of Supervisor
May we Contact this Organization	Supervisors E-Mail Address	Supervisors Phone Number

Duties:

Position Title	Organization Name	Dates
City, State	Average Hours per Week	Name of Supervisor
May we Contact this Organization	Supervisors E-Mail Address	Supervisors Phone Number

Duties:

ACHIEVEMENTS

Name	Organization	Date
Name	Organization	Date
Name	Organization	Date

LICENSES AND CERTIFICATIONS

Type	State	Number
Type	State	Number
Type	State	Number

CREDENTIALS AND CERTIFICATIONS

Certification/ Credential Type	Issue Organization	Certification Number	Certification Date	Expiration Date
Certification/ Credential Type	Issue Organization	Certification Number	Certification Date	Expiration Date
Certification/ Credential Type	Issue Organization	Certification Number	Certification Date	Expiration Date

MEMBERSHIPS

Name

Name

Name

SUPPLEMENTAL QUESTIONS

What do you wish to gain through participation in a residency program?

Discuss aspects of your background that professional experience that particularly qualify you for participation in a residency program.

Have you found your professional passion, and if so, what is it? How does the residency program fit in your plans for following this passion?

REFERENCES

All 3 references must be from licensed Occupational Therapists, with at least one being from a Fieldwork Educator, and another from an Occupational Therapist Academician.

Name	Title
Organization	Occupation
Date	Email Address

Name	Title
Organization	Occupation
Date	Email Address

Name	Title
Organization	Occupation
Date	Email Address