



**DEPARTMENT OF OCCUPATIONAL THERAPY
Western Michigan University**

**POST PROFESSIONAL MASTERS DEGREE PROGRAM
FOR REGISTERED OCCUPATIONAL THERAPISTS**

Department Application

Date: _____ **SS#:** _____

Name: _____
Mr/Ms

Home Address: _____

Email Address: _____

Home Telephone: _____

Work Telephone: _____

Undergraduate Degree Information:

Institution: _____

Degree: _____ **Date of Graduation:** _____

Minor: _____

Signature: _____

EXPERIENCE DOCUMENTATION

Please list professional work related to occupational therapy

Position: _____

Agency: _____

Address: _____

Brief job description: _____

Length of time: _____

Position: _____

Agency: _____

Address: _____

Brief job description: _____

Length of time: _____

(If others, please complete a separate page and attach.)

RETURN THIS FORM TO:

**Graduate Advisor
Department of Occupational Therapy
Western Michigan University
Kalamazoo, MI 49008**