**Read the following instructions carefully.** Please type or print legibly in black ink. Application materials must include the below items to be considered complete and valid. **Incomplete applications with missing information or forms will not be considered.**

To start the application process, email alliedhealthadmissions@dcccd.edu with the subject line “OTA application.” In the email, please include your full name, Dallas College student ID and the email address where you would like to have the application instructions sent (if different from the one used to request the application instructions). Allied Health Admissions will provide information on uploading the documents required for application, as well as further directions on completing the application process.

Necessary for a full application to the Dallas College OTA Program:

[ ]  Complete an admission application for Dallas College, if not already a Dallas College student. (OTA applicants must have a High School Diploma or GED.)

[ ]  Submit official transcripts from ***all*** previously attended colleges/universities to studenttranscripts@dcccd.edu or to Dallas College, ATTN: Admissions Processing, 3737 Motley Drive, Mesquite, TX 75150 by the deadline.

[ ]  Complete the [Texas Success Initiative](https://www.dallascollege.edu/admissions/tsi/pages/default.aspx) requirements. See a Success Coach as needed for TSI counseling, placement testing, etc. and complete any developmental courses as may be prescribed from test scores.

[ ]  Complete the six (6) OTA prerequisite courses with a cumulative GPA of 2.75 or higher and a “C” or better in each course, as well as an overall GPA of 2.75.

[ ]  Take the TEAS Test before OTA deadline with a score of 65 or higher. Higher scores are given higher rankings on the *Admission Worksheet Rubric*.

[ ]  Create a SurScan account (follow these instructions [PDF](https://www.dallascollege.edu/SiteCollectionDocuments/docs/cd/credit/occupational-therapy/ota-surscan-registration-print.pdf)). Uploads will include: physical exam form, immunization records, TB screening documentation, proof of medical insurance and proof of current Healthcare provider-level CPR certification (photocopy of front and back of CPR card). See a physician or healthcare clinic for a physical examination, immunizations, TB screening, etc., and obtain Healthcare provider-level CPR certification. A background check and drug screening will be required before starting the OTA Program.

The following must be submitted per the instructions of Allied Health Admissions:

☐ Occupational Therapy Assistant Program Application (this document)

[ ]  All observation feedback forms or certificates of completion with signatures. This includes a total of 40 hours (20 hours at two (2) different areas of practice).

[ ]  Three (3) recommendation forms/letters. One (1) letter needs to be from an OT/OTA and two (2) letters can be a professional recommendation (co-worker, professor, etc.).

[ ]  Photocopy of your Social Security card

☐ Photocopy of your Driver License or State ID card

☐ Letter verifying previously earned credentials or training from a related field that demonstrates prior knowledge.

I am applying for the OTA Program and will submit all required documents to Allied Health Admissions. I understand this is not acceptance into the program; this is the beginning of the application process. I have reviewed my application and to the best of my knowledge have determined that all requirements have been met and submitted on time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Applicant Date

This application will be used in the accumulation of points for the admission process. Students admitted are aware that Dallas College at Mountain View Campus is accredited per ACOTE. Final decisions on point allocation will be determined by the program director.

I hereby certify the information in this application is true and complete to the best of my knowledge. I understand that any misrepresentation or falsification is cause for denial of admission or expulsion from the college. I understand the faculty and staff of Dallas College Occupational Therapy Assistant Program will read the information contained in this application.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Applicant Date

Please type or print legibly in black ink.

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Social Security #: Dallas College ID#: Texas Driver’s License/ID #: DL/ID EXP Date:

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Last Name: First Name: MI:

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Mailing Address: Street: Apartment #

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Mailing Address City: State: Zip Code:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: Cell Phone: \*Email Address:

**\*MANDATORY – Notifications will be made via email. Please ensure email address is correct and legible.**

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Date of Birth DD/MM/YYYY: Age:

Gender: [ ]  Male [ ]  Female [ ]  Non-binary [ ]  Other

Ethnicity: [ ]  Hispanic/Spanish/Latino [ ]  Caucasian/White [ ]  Black/African American [ ]  Asian

 [ ]  American Indian/Alaskan Native [ ]  Native Hawaiian/Pacific Islander [ ]  2 or more Races

[ ]  Other/Prefer not to say

Health Insurance: [ ]  Yes [ ]  No Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Emergency Contact: Last Name: First Name: Phone:

Emergency Contact, Relationship to You (mother, sibling, spouse, friend, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a [ ]  High School Diploma or [ ]  GED? Month/Year MM/YYYY Awarded? \_\_\_\_\_\_\_\_\_\_\_

**\*All Applicants must have a GED or High School Diploma to Apply.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Highest Degree Earned (diploma, associate, bachelor’s, etc.) Month/Year (MM/YYYY) Awarded

Have you previously accepted or enrolled in another OT or OTA Program? [ ]  Yes [ ]  OT or [ ]  OTA [ ]  No

If yes, please list the school(s) under prior education.

Can we notify the school(s)? [ ]  Yes [ ]  No

**Prior Education (List most recent first…)**

| **GED Program,****High School,** **Colleges Attended** | **Location****(City, State, Zip)** | **Attendance Dates From/To MM/YY - MM/YY** | **Credit Hours Earned** | **Date Degree/ Certificate/ Diploma Conferred** |
| --- | --- | --- | --- | --- |
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**\*All Applicants must have a GED or High School Diploma to Apply.**

**Employment Record (list most recent or present position first)**

| **Company Name** | **Date(s) Employed** | **Position & Duties** |
| --- | --- | --- |
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Dallas College Academic Policy is that the most recent attempt is counted as your

official grade. In this section, enter the grade from your most recent attempt at each

course. Also, BIOL 2401 and BIOL 2402 MUST have been completed less than five (5)

years from the start of your program (not the application date).

**Prerequisite Requirement Table**

| **Course Name & Number** | **Semester & Year Taken** | **Final Grade** | **School where Course was taken** |
| --- | --- | --- | --- |
| ENGL 1301 Composition I |  |  |  |
| PSYC 2301 General Psychology |  |  |  |
| PSYC 2314 Lifespan Growth and Development |  |  |  |
| BIOL 2401 A&P I (Lecture/Lab) |  |  |  |
| BIOL 2402 A&P II (Lecture/Lab) |  |  |  |
| + Elective Humanities/Fine Arts  |  |  |  |

Observation Hours: Please fill out the following information AND submit two (2) signed *Observation/Volunteer Record* Form. *(40 Hours Total (20 Hours in two different areas/settings))*.

| **Name of Facility** | **Type of Setting** | **Number of Hours** |
| --- | --- | --- |
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To be filled out by the Applicant

**Health Record**

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Last Name: First: Middle: DOB: (DD/MM/YYYY) Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: Street: City: & State: Zip Code:

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Telephone: Home: Work: Cell:

**Health Questionnaire**

I certify that I have:

1. Visual acuity, with or without corrective lenses. This includes but is not limited to the ability to complete a patient assessment, read small print, visualize, and interpret monitors, and equipment calibrations.

Yes\_[ ] \_ No\_[ ] \_ If No, Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Hearing ability with or without auditory aids to understand the normal speaking voice without viewing the speaker’s face. This includes but is not limited to hearing monitor alarms, emergency signals, patient call bells, and stethoscope sounds originating from the patient’s blood vessels, heart, lungs, and abdomen. Yes\_[ ] \_ No\_[ ] \_ If No, Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Physical ability to stand for prolonged periods of time and a reasonable level of strength and endurance. This includes but is not limited to the ability to lift a minimum of 50 pounds, perform cardiopulmonary resuscitation, lift patients, move from room to room, maneuver in small spaces, and complete twelve-hour shifts. Yes\_[ ] \_ No\_[ ] \_ If No, Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Ability to communicate effectively orally, aurally, and in writing. This includes but is not limited to the ability to speak clearly and understandably to members of the health care team, patients, and families. The student must possess the ability to write legibly and professionally and use effective listening skills. Yes\_[ ] \_ No\_[ ] \_ If No, Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Manual dexterity, strength, gross motor, and fine motor skills. This includes but is not limited to the ability to utilize sterile technique, turn, and move patients, and perform other OTA procedures/skills.

Yes\_[ ] \_ No\_[ ] \_ If No, Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Reliable personal transportation and ability to attend all classroom and clinical experiences, both on and off campus. Yes\_[ ] \_ No\_[ ] \_ If No, Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. A normal level of health and immunity. This includes but is not limited to the ability to tolerate immunizations and to work with a wide variety of potentially contagious patients. Yes\_[ ] \_ No\_[ ] \_ If No, Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Ability to function safely and professionally under various stressful conditions. Yes\_[ ] \_ No\_[ ] \_ If No, Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Eligibility to meet The National Board of Certified Occupational Therapist & The Executive Council of Physical Therapy and Occupational Therapy Examiners Licensure Requirements. This includes but is not limited to passing a criminal background check and random drug and alcohol screenings. **If drug/alcohol testing comes back with positive results that is an automatic dismissal from MVC OTA program.**  (Please be aware that some criminal history or psychiatric illnesses may preclude an individual from licensure eligibility Yes\_[ ] \_ No\_[ ] \_ If No, Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please answer the following question:

1. Do you have any other conditions which might interfere with your ability to practice occupational therapy? Yes\_[ ] \_ No\_[ ] \_ If Yes, Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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