

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

- *Resume/CV*
- *Copy of Professional License/Certification*
- *Copy of Occupational Therapy School Transcript*

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

PLEASE SUBMIT ALL MATERIALS TO KAITLYN GREEN NO LATER THAN **January, 22, 2021 @ 11:59PM:**

3599 University Blvd South  
 Jacksonville, FL 32216  
[info@brooksihl.org](mailto:info@brooksihl.org)  
 O: 904.345.7071  
 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
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**

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

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

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

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**REFERENCES <https://bihl.wufoo.com/forms/ms3437817sg7kl/>**

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. References should be submitted using the following link: <https://bihl.wufoo.com/forms/ms3437817sg7kl/> / Reference Submission Click Here

Name	Title
Organization	Occupation
Date	Email Address

Name	Title
Organization	Occupation
Date	Email Address

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Organization	Occupation
Date	Email Address