
THE THERAPY SOLUTIONS OF GEORGIA, INC.

3615 BRASELTON HIGHWAY · SUITE 103 · DACULA, GEORGIA 30019-5907

STUDENT OBSERVATION REQUEST

Student Name: _____ DOB: _____
(Must be at least 18 years old or older)

Address: _____ Home Phone: () - _____
_____ Cell Phone: () - _____

Email Address: _____

Emergency Contact: _____ Phone: () - _____

I am a student at: _____

I am interested in Occupational Therapy Speech Therapy

I am a Junior Senior Post Graduate Other _____

I am a member of The Georgia Occupational Therapy Association (GOTA) www.gaota.com

I am a member of The Georgia Speech-Language-Hearing Association (GSHA) www.gsha.org

GOTA Member Number: _____ GSHA Member Number: _____

*Note: First consideration will be given to students that are members of their related state association.

Available times for observation: _____

STUDENT OBSERVER AGREEMENT

I, _____, agree that I will uphold the highest standards of behavior when participating in educational activities/observations at Therapy Solutions of Georgia, Inc. I understand that any information that is discussed while participating in or observing therapy at Therapy Solutions of Georgia, Inc. is to remain confidential and should not, under any circumstances be discussed outside of Therapy Solutions of Georgia, Inc. I agree to remain with the appropriate therapist in the treatment rooms at all times and not to engage in manipulation of any piece of equipment without explicit permission from a staff member of Therapy Solutions of Georgia, Inc.

Therapy Solutions of Georgia, Inc. encourages the interest in, and the pursuit of, occupations in health care services that benefit children and their families. This organization strives to provide innovative, top-quality therapeutic services to our clients and in the pursuit of our mission and vision we also take responsibility for stimulating the interest and education of future Occupational and Speech therapists in the community. I understand that should my behavior be inconsistent with the mission of this agency, I will be asked to discontinue my affiliation immediately.

In consideration for the privilege to participate as a student observer the undersigned does hereby agree to hold harmless and indemnify Therapy Solutions of Georgia, Inc., its affiliates and subsidiaries, owners and principals, and employees and contractors and further release them from any liability or responsibility for accident, damage, injury, illness or death to the undersigned or property owned by the undersigned. Furthermore, I understand and agree that I will be both civilly and criminal responsible for failure to maintain compliance with the policies set by Therapy Solutions of Georgia, Inc. as well as those requirements set by law.

I agree with these policies and procedures and promise to abide by them during and after my affiliation with this agency.

Printed Name

Signature

Date

This form should be completed in its entirety and faxed to (678) 377-9609

PHONE: (678) 377-9634 · FAX (678) 377-9609