



Assistive Technology Partners

Department of Physical Medicine and Rehabilitation

Graduate Student Application: Advanced Training in Assistive Technology

Applicant Information

Full Name: _____ Date: _____
Last First M.I.

Home Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Phone: () _____ E-mail Address: _____
 Work Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Phone: () _____ E-mail Address: _____

Are you a citizen of the United States? YES NO

Please indicate best method to contact you. _____

References

Please list three professionals you have contacted to send letters of reference

Full Name: _____ Relationship: _____
 Company: _____ Phone: () _____
 Address: _____

Full Name: _____ Relationship: _____
 Company: _____ Phone: () _____
 Address: _____

Full Name: _____ Relationship: _____
 Company: _____ Phone: () _____
 Address: _____

AT Research or Field Experiences

Location _____ From: _____ To: _____
 Responsibilities: _____

Location _____ From: _____ To: _____
 Responsibilities: _____

Location _____ From: _____ To: _____
 Responsibilities: _____

Disclaimer and Signature

