ALOFT

AMERICAN LEAGUE OF FUNCTIONAL THERAPISTS, LLC
APPLICATION FOR STUDENT REGISTRATION AS A
STUDENT FUNCTIONAL THERAPIST SFT
OR
STUDENT FUNCTIONAL THERAPY ASSOCIATE SFTA

For Office Use Only
License # _____
Verified _____
Issue Date _____
Exp. Date _____

Working Towards: SFT (OT Student) / SFTA (OTA Student) or Pre-SFT / Pre-SFTA
Fees: One Time Charge: $30 *(Membership fees are fully refundable for 90 days.)*

Registration is for the entire period you are a student of Occupational Therapy studies. You must be accepted to an OT or OTA program to qualify as a SFT or SFTA. If you are planning to go into one of these programs you may join as a Pre-SFT or Pre-SFTA; once admitted you can change your status with no additional cost.
(Upon graduation, your student membership fee will be applied against your initial application fee as a $30 credit. We would like you to be involved from the earliest part of your OT or OTA education.)
☐ **Changing status** (Pre-SFT(A) to Student Status)**: _____**

Last Name: _____ First Name: _____ MI: _____ Maiden Name: _____

Date of Birth (mm/dd/yyyy): _____/_____/_____ Gender: M / F

Name and Mailing Address: This will be how your name will appear on your official certificate of registration, your address of record for all mailings from this office and releasable pursuant to Freedom of Information requests. It will not be traded or sold.

Name as it will appear on Certificate of Registration: _____
Address: _____
_____
City, State, Zip: _____

Daytime Phone Number: (____) ____-_____ Evening Phone Number: (____) ____-_____
E-mail: _____ Other: _____

OT / OTA Institution of Record: _____, Diploma Sought: _____,
Address: _____,
Website (optional): www._____, Dates Attended (mm/yyyy – mm/yyyy): ___/_____ - ___/_____,
Other Post Secondary Institutions Attended:
Institution: _____, Dates Attended (mm/yyyy – mm/yyyy): ___/_____ - ___/_____,
Institution: _____, Dates Attended (mm/yyyy – mm/yyyy): ___/_____ - ___/_____,
(Please attach additional Post Secondary institutions on a separate sheet.)

Other memberships, interests, or activities you would like us to be aware of (optional): _____
_____

I hereby certify that the statements I have made on this form are true to the best of my knowledge. I am seeking student admission to the American League of Functional Therapists.

_____ _____
SIGNATURE OF APPLICANT DATE ***SIGNATURE OF WITNESS & PRINTED NAME DATE***

(*ALOFT reserves the right to independently verify any information related to this application; we may contact you for supporting documentation or other information while verifying your application. Inaccuracies may delay your registration or limit your ability to become a registered member of the American League of Functional Therapists, LLC.)*

Applicant: Please return *this signed application* (1), along with a *copy of a document verifying student status* (2), and the applicable *application fee* (3) in the form of a check, certified funds or money order made payable to: "ALOFT". Send this to:

ALOFT Admissions
P.O. Box 29
Stratford, CT 06615
Questions: RFT@functionaltherapist.org

To expedite your application
Fax your application and documents to:
(888) 389-7933