

EAST COAST THERAPIES

Clinical Career & Employment Application

Please complete this application to help us understand your clinical background, professional goals, and alignment with our mission to provide high-quality pediatric therapy across Horry County.

1. APPLICANT & DISCIPLINE DETAILS

Full Legal Name:	Phone Number:	Email Address:
Mailing Address:	SC License Number / Status:	Desired Start Date:

Clinical Discipline (check all that apply):

☐ Occupational Therapist (OT) ☐ Occupational Therapy Assistant (OTA / COTA) ☐ Speech-Language Pathologist (SLP)

☐ Physical Therapist (PT) ☐ Other: _____

2. EMPLOYMENT PATH & SCHEDULE PREFERENCES

Employment Type Desired:	Schedule Commitment:
☐ W-2 Employee (with Benefits)	☐ Full-Time (4–5 days/week) ☐ Part-Time (1–3 days/week)
☐ 1099 Independent Contractor	
Desired Compensation (Treatment Rate / Hourly / Salary):	Desired Evaluation Rate (if applicable):

3. CLINICAL EXPERIENCE SNAPSHOT

General Pediatric Experience:

☐ Student / Fieldwork only ☐ < 1 Year ☐ 1–3 Years ☐ 4–7 Years ☐ 8+ Years

Early Intervention (0–3 Years) Experience:

☐ None / Limited ☐ Fieldwork / Clinical Rotation ☐ 1–2 Years ☐ 3+ Years

Feeding, Eating & Swallowing Experience:

☐ None ☐ Basic / Sensory Picky Eaters ☐ Oral Motor / Dysphagia ☐ Specialized Training (e.g., SOS, Beckman)

4. PROFESSIONAL DEVELOPMENT & CULTURE

Did our Tidal Academy and structured approach to onboarding and ongoing professional development have an influence on your decision to apply with East Coast Therapies?

☐ Yes ☐ No *Comments (optional):* _____

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Applicant Name: _____ | Date: _____

5. PROFESSIONAL REFERENCES (MINIMUM 3 REQUIRED)

Please provide at least 3 professional or clinical references (clinical instructors, supervisors, colleagues, or mentors).

Reference Name & Title	Organization / Relationship	Phone Number	Email Address

6. CANDIDATE PERSONAL STATEMENT

In your own words, please share what motivates you to practice pediatric therapy, why you want to join East Coast Therapies, and how you hope to make an impact serving children and families across Horry County:

7. APPLICANT ACKNOWLEDGMENT & SIGNATURE

I certify that all information provided in this application is true, accurate, and complete to the best of my knowledge. I authorize East Coast Therapies to contact the references listed above to verify my clinical background and qualifications.

Applicant Signature: _____

Date: _____