PLEASE PRINT:

Student Name: ________________________________

Name of Facility where student observed: ________________________________

Street Address, City, State of Facility ________________________________

____________________________________________________________________

Name of Occupational Therapist who supervised you during the observation experience and/or can verify your OT observation hours.

____________________________________________________________________

OT License Number __________________ State of OT License ________________

OT Email Address ______________________________ OT Phone Number ___________ - ________ - ________

Type of Experience: ________ Inpatient ________ Outpatient experience ________ Observation only

__________ Paid ________ Volunteer Experience

OT Setting (Select all that apply):

_____ Children and Youth _____ Work and Industry _____ Mental Health

_____ Rehabilitation _____ Health and Wellness _____ Productive Aging

_____ Other ______________________________

Start Date ______________________________ End Date ______________________________

Total Number of Hours Over Span of Experience: __________________

Signature of OT: ________________________________

Signature of Student: ________________________________

April, 2018  http://www.wcupa.edu/_ACADEMICS/HealthSciences/kinesiology/undergrad.asp