**Master of Occupational Therapy**

**DOCUMENTATION OF EXPERIENCE**

*This form is to be completed by the applicant and verified by the Occupational Therapist supervising the experience.*

|  |  |
| --- | --- |
| **APPLICANT’S SECTION** |  |
| Name | **Office use only. Do not write in this box.**HSC Badge # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address |  |  |
| Phone |  |  |
|  |  |  |
| **OCCUPATIONAL THERAPIST’S SECTION** |
| Name | Title |  |
| Facility Name/Address | Phone |  |
|  |
| **VERIFICATION OF EXPERIENCE** |
| Volunteer/observation dates | / |  | through | / |  |
|  | month | year |  | month | year |
|  |  |  |  |  |  |  |
|  |  | Volunteer/observer |  |  |  | Paid employee |
|  |  | Approximate # of hrs. \_\_\_\_\_ |  |  |  | Approximate # of hrs.\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |
| Type of facility: |  | Acute care hospital |  | Rehabilitation hospital |  |  |
|  |  | Long term care |  | Home health |  |  |
|  |  | School system |  | Out-patient clinic |  |  |
|  |  | Skilled nursing facility |  | Other \_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  |  |  |  |  |  |
| Type of patients observed: |  | Orthopedics |  | Hand therapy |  | Neurological |
|  |  | Spinal cord injury |  | Pediatrics |  | Amputees |
|  |  | Burns |  | Psychiatric |  | Other \_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |
| Treatment modalities observed: |  | Exercise |  | Positioning |  | Recreational |
|  |  | Family training |  | Work hardening |  | Splinting |
|  |  | ADL training |  | Mobility training |  | NDT training |
|  |  | Developmental training |  | Cognitive rehab |  | Other \_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| I certify that the information provided is complete and correct. |
|  |
|  |
|  |  |
| Occupational Therapist’s Signature | Date |

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