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

**APPLICANT'S SECTION**

Name

Address

Phone

By checking this box, I agree I completed the Occupational Therapy Online Shadowing Experience: [https://rise.articulate.com/share/ogbmWqPTs5TB36aI5R7DUMblwYkJiY_Y#/](https://rise.articulate.com/share/ogbmWqPTs5TB36aI5R7DUMblwYkJiY_Y#/)

**OCCUPATIONAL THERAPIST’S SECTION**

Name

Title

Facility Name/Address

Phone

**VERIFICATION OF EXPERIENCE**

Volunteer/observation dates / through / month year

- Volunteer/observer
- Paid employee

Approximate # of hrs. ______

Approximate # of hrs. ______

Type of facility:

- Acute care hospital
- Long term care
- School system
- Skilled nursing facility
- Rehabilitation hospital
- Home health
- Out-patient clinic
- Other _____________

Type of patients observed:

- Orthopedics
- Spinal cord injury
- Burns
- Hand therapy
- Pediatrics
- Psychiatric
- Neurological
- Amputees
- Other _____________

Treatment modalities observed:

- Exercise
- Family training
- ADL training
- Developmental training
- Positioning
- Work hardening
- Mobility training
- NDT training
- Cognitive rehab
- Recreational
- Splinting
- Other _____________

I certify that the information provided is complete and correct.

Occupational Therapist’s Signature

Date

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