



Doctor 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, Address, Phone fields. Office use only box for HSC Badge #.

By checking this box, I agree I completed the Occupational Therapy Online Shadowing Experience: https://rise.articulate.com/share/oqbmWqPTs5TB36al5R7DUMblwykjiY_Y#/

OCCUPATIONAL THERAPIST'S SECTION

Name, Title, Facility Name/Address, Phone fields.

VERIFICATION OF EXPERIENCE

Volunteer/observation dates field with month/year and through month/year options.

Checkboxes for Volunteer/observer and Paid employee, with approximate # of hrs. fields.

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, Cognitive rehab, Recreational, Splinting, NDT training, Other.

I certify that the information provided is complete and correct.

Occupational Therapist's Signature and Date fields.