**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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