



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, Office use only. Do not write in this box. HSC Badge #

OCCUPATIONAL THERAPIST'S SECTION

Name, Title, Facility Name/Address, Phone

VERIFICATION OF EXPERIENCE

Volunteer/observation dates month/year through month/year

Volunteer/observer, Paid employee, 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