SCHOOL OF HEALTH PROFESSIONS
UT HEALTH SCIENCE CENTER®
SAN ANTONIO

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
☐ Approximate # of hrs. _____

☐ Paid employee
☐ 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
☐ Cognitive rehab
☐ Recreational
☐ Splinting
☐ NDT training
☐ Other _____

I certify that the information provided is complete and correct.

Occupational Therapist's Signature Date