



Documentation Form for Occupational Therapy Observation

(Please Print)

Applicant Name: _____

Name of Facility: _____

Address of Facility: _____

Phone # of Facility: _____

Practice Setting:

____ acute care ____ rehab ____ outpatient ____ pediatrics ____ mental health

Other setting: _____

_____ hours of experience were completed as a: ____ volunteer ____ employee

These hours (please choose):

____ fulfill the 10-hour requirement for admission into the MOT program

____ fulfill the 30-hour requirement for progression into the MOT program

____ fulfill the 50-hour requirement for graduate admission into the MOT program

____ fulfill the 25/50-hour requirement as part of the OT301/302 exemption policy

____ fulfill the general observation hours required as part of the process of transferring into the OT program
(external or internal)

Inclusive Date(s): _____

Occupational Therapy Practitioner Contact Information

Name (with credentials): _____

Email Address: _____

License #: _____

Signature of Student: _____

Signature of OT Practitioner: _____

FOR OFFICE USE:

Date verified: _____

Signature: _____