

# West Chester University

## DOCUMENTATION SHEET

### OCCUPATIONAL THERAPY (PT) OBSERVATION HOURS

FOR STUDENTS ENROLLED IN THE B.S. IN EXERCISE SCIENCE PRE-OT CONCENTRATION

PLEASE PRINT:

Student Name: \_\_\_\_\_

Name of Facility where student observed: \_\_\_\_\_

Street Address, City, State of Facility \_\_\_\_\_

\_\_\_\_\_

Name of Occupational Therapist who supervised you during the observation experience and/or can verify your OT observation hours.

\_\_\_\_\_

OT License Number \_\_\_\_\_ State of OT License \_\_\_\_\_

OT Email Address \_\_\_\_\_ OT Phone Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Type of Experience: \_\_\_\_\_ Inpatient \_\_\_\_\_ Outpatient experience \_\_\_\_\_ Observation only

\_\_\_\_\_ Paid \_\_\_\_\_ Volunteer Experience

OT Setting (Select all that apply):

\_\_\_\_\_ Children and Youth \_\_\_\_\_ Work and Industry \_\_\_\_\_ Mental Health

\_\_\_\_\_ Rehabilitation \_\_\_\_\_ Health and Wellness \_\_\_\_\_ Productive Aging

\_\_\_\_\_ Other \_\_\_\_\_

Start Date \_\_\_\_\_ End Date \_\_\_\_\_

Total Number of Hours Over Span of Experience: \_\_\_\_\_

Signature of OT: \_\_\_\_\_

Signature of Student: \_\_\_\_\_