West Chester University

DOCUMENTATION SHEET

OCCUPATIONAL THERAPY (OT) 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:_____