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:** | I**npatient** | **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:

April, 2018 <http://www.wcupa.edu/_ACADEMICS/HealthSciences/kinesiology/undergrad.asp>