

**DOCUMENTATION OF OBSERVATION EXPERIENCE**

*This form is to be completed by the applicant and verified by the occupational therapist supervising the observation experience.*

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| **Applicant’s Section** | **Occupational Therapist’s Section** |
| Printed Name:  | Printed Name: |
| Address: | Title: |
|  | Facility name: |
| Phone: | Facility address: |
| Email:  | Phone and/or email: |

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| **Verification of Observation Experience** |
| Observation Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_through\_\_\_\_\_\_\_\_\_\_\_\_\_ | Approximate number of hours: |
| Type of facility (Please circle all that apply, below): |
| Acute care hospital Long term care School system Skilled nursing facility Rehabilitation hospital Home health Outpatient clinic Mental health Community program Organizational program Workplace intervention Early Intervention Primary Care setting Private practice Other: |
| Type of clients (Please circle all that apply, below) : |
| Pediatrics Adults Individual treatment Group treatment Clients with disability-related needs Clients with non-disability related needs Clients at-risk for disability, illness, etc. Other: |
| Types of interventions observed (Please circle all that apply, below): |
| Participation in daily life activities/ADLs Modalities Splinting Assistive technology Environmental Modification Wheelchair assessment MassageMobility training Positioning Exercise/Strengthening Caregiver education Client education Health promotion Play/Leisure Work Hardening Maintenance activities Sensory Integration Remediation/restoration activities Cognitive rehabilitation Developmental activities  |

Comments:

Occupational Therapist’s Signature Date