Occupational Therapy Assistant Program

Job Shadow/Experience in OT Verification

Student Name_____ S Number_____

Experience Verification: <u>Supervising clinician must fill out this form.</u> Student must also sign attesting that the information below is correct.

The student above has volunteered, observed, or been employed in the occupational therapy department at this facility for a total of _____hours from _____/_____/_____ to _____/_____/_____.

Name of Facility_____

Address_____

Phone_____Email_____

Type of Facility_____

Name of OT/OTA and credentials_____

Clinician Signature_____Date_____

Student Signature_____Date_____

Once completed, the student can submit this form with the application.