

The University of Texas Health Science Center at San Antonio
School of Allied Health Sciences
7703 Floyd Curl Drive
San Antonio, Texas 78229-3900

Master of Occupational Therapy

DOCUMENTATION OF EXPERIENCE

This form is to be completed by the applicant and verified by the Occupational Therapist supervising the experience.

APPLICANT'S SECTION

Office use only. Do not write in this box.

Applicant's Name _____

HSC Badge # _____

Applicant Address _____

Applicant Phone # (____) _____

OCCUPATIONAL THERAPIST'S SECTION

Occupational Therapist's Name _____ Title _____

Facility Name/Address _____ Phone (____) _____

VERIFICATION OF EXPERIENCE

Volunteer/Observation Dates _____/_____/_____ through _____/_____/_____
month year month year

Volunteer/observer
Approximate # of hrs. _____

Paid employee
Approximate # of hrs. _____

Type of facility:

- | | |
|---|--|
| <input type="checkbox"/> Acute care hospital | <input type="checkbox"/> Rehabilitation hospital |
| <input type="checkbox"/> Long term care | <input type="checkbox"/> Home health |
| <input type="checkbox"/> School system | <input type="checkbox"/> Out-patient clinic |
| <input type="checkbox"/> Skilled nursing facility | <input type="checkbox"/> Other _____ |

Type of patients observed:

- | | | |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Orthopedics | <input type="checkbox"/> Hand therapy | <input type="checkbox"/> Neurological |
| <input type="checkbox"/> Spinal cord injury | <input type="checkbox"/> Pediatrics | <input type="checkbox"/> Amputees |
| <input type="checkbox"/> Burns | <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Other _____ |

Treatment modalities observed:

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Positioning | <input type="checkbox"/> Recreational |
| <input type="checkbox"/> Family training | <input type="checkbox"/> Work hardening | <input type="checkbox"/> Splinting |
| <input type="checkbox"/> ADL training | <input type="checkbox"/> Mobility training | <input type="checkbox"/> NDT training |
| <input type="checkbox"/> Developmental training | <input type="checkbox"/> Cognitive rehab | <input type="checkbox"/> Other _____ |

I certify that the information provided is complete and correct.

Occupational Therapist's Signature _____

Date _____