Career Development
& Exploration

Occupational Therapy Student Observation Documentation

To be Completed by Student

Student Name:____

Name of Facility:____

Street Address for Facility:__________________________________

City:________________________ State:______ Zip Code:__________

Occupational Therapist Name:____________________ OT:______ or OTA:______

OT/OTA Email Address:____________________ OT/OTA Phone:______________

Paid or Volunteer Experience: Paid ____ Volunteer ____ Both ____

Type of Clinical Setting: (Please check all that apply)

_______Nursing Home

_______Hospital

_______Home and Community Health

_______School System

_______Mental Health

_______Physical Disabilities

_______Developmental Disabilities

_______Geriatrics

_______Children or Youth

_______Adults

Date	Time In	Time Out	Hours	Population or Age Seen	Primary Diagnosis

TOTAL HOURS AT THIS SETTING_________

To be Completed by OT/OTA

Signature of Supervising OT/OTA:________________________ Date:__________

OT/OTA License Number:________________________ State:__________

Leave blank, if unknown

* These hours are in preparation for application to Master of Occupational Therapy or Occupational Therapy Doctorate Programs. Cleveland State University's Master of Occupational Therapy Program does not require these forms. If there are any questions or concerns, please contact Career Development & Exploration at 216-687-2233 or careers@csuohio.edu. Please make as many copies of this form as necessary to record your observation/volunteer/ paid work hours. Use one form for each practice setting or population.