Cleveland State University
College of Sciences and Health Professions

College of Sciences and Health Professions
Pre-Professional Health Programs
https://www.csuohio.edu/sciences/pre-professional-programs

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 the Office of Pre-Professional Health Programs at 216-687-9321 or coshpadvising@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.