FAULKNER
DEPARTMENT OF OCCUPATIONAL THERAPY

OT Observation Hours

Name of Facility:		
Type of OT setting:	Circle one: Inpatient Outpatient	
Name of Occupational Therapist:		
State of OT License:	OT License #:	OT phone:
OT email:		

Date	Start time	Finish time	Hours	OT Int.

Total hours completed:_____

OT signature:_____ Date:_____

Student signature:_____ Date:_____

Print student name:_____