Quinnipiac
Occupational Therapy

Occupational Therapy Observation Hours Verification Form

Name of the Applicant:_____

Name of Facility:_____

Name of Supervising Occupational Therapist:_____

Facility Contact Information:_____

Description of the Occupational Therapy activities observed:_____

_____

_____

_____

_____

_____Total Hours:_____

I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE.

Student's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____