



Observation/Volunteer Record Occupational Therapy Assistant Program

*Submit one form for **each** facility in which observation/volunteer hours were completed.*

STUDENT NAME (PRINT) _____

This applicant has (please check):

Worked or Observed/Volunteered under my supervision.

Name and Credentials: _____ License # _____ State _____

Facility Name: _____

Address: _____

Phone Number:(_____) _____ Email: _____

Signature: _____

Date	Time In	Time Out	Total	OTR/COTA Initials

TOTAL HOURS _____

By signing this form, I certify that I have completed the hours as recorded above.

Applicant Signature and Date: _____