OCCUPATIONAL THERAPY ASSISTANT PROGRAM

Documentation Form for Work Experience

Name of Applicant _____
Last First Middle

Social Security Number _____ Phone Number _____

Signature of Applicant _____

Facility Name _____ Phone Number _____

Facility Address _____

_____

OT Aides:

The above applicant worked (Circle one: paid full-time or paid part-time) at my facility from

_____ to _____ as an Occupational Therapy Aide under my direct supervision.

_____ OTR/COTA _____ _____
Signature of OT Supervisor (Circle one) License Number Print Name

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Non-OT Aides:

The above applicant worked (Circle one: paid full-time or paid part-time) at my facility from

_____ to _____ as a(n) _____
(Job Title)

This job is related to occupational therapy in the following way: _____

_____

_____

_____ _____ _____
Signature Print Name Title

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