THE SCHOOL OF HEALTH SCIENCES
TOURO UNIVERSITY

Occupational Therapy Program
OT Observation Hours Form

This form should be **uploaded** to your OTCAS application.

OCCUPATIONAL THERAPY OBSERVATION HOURS

To be completed and signed only by the Supervisor.

Applicant Name: _____

Facility: _____

Supervisor: _____

Clinical Setting: [ ]Hospital [ ]Private Office [ ]Clinic [ ]Other: _____

Area of Practice: _____

Date(s): _____ **Number of Hours completed:** _____

Description of duties/comments:

Signature of OT Supervisor: _____ **Date:** _____

Supervisor OT contact information: Phone: _____**Email:** _____

Supervising OT license #_____