DOCUMENTATION OF OBSERVATION EXPERIENCE

Master of Occupational Therapy and Doctor of Physical Therapy

APPLICANT NAME: ______________________________ **SSN:** ____________________

I have completed volunteer or paid work at the following facility(s).

Name and Address of Facility:

______________________ Clock Hours __________ Dates ____________________
______________________ Supervisor ______________________________
______________________ Telephone Number __________ Email address ______________

Name and Address of Facility:

______________________ Clock Hours __________ Dates ____________________
______________________ Supervisor ______________________________
______________________ Telephone Number __________ Email address ______________

Name and Address of Facility:

______________________ Clock Hours __________ Dates ____________________
______________________ Supervisor ______________________________
______________________ Telephone Number __________ Email address ______________

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______________________ Telephone Number __________ Email address ______________

Name and Address of Facility:

______________________ Clock Hours __________ Dates ____________________
______________________ Supervisor ______________________________
______________________ Telephone Number __________ Email address ______________

I authorize the above named facility(s) to release any information regarding my volunteer/work experience to the College of Allied Health. I understand that submitting any false information to the College of Allied Health will make my application for admission, as well as any future applications, subject to denial, or will result in expulsion from the College. I also understand that all documents submitted to the College of Allied Health, University of Oklahoma Health Sciences Center, become the property of the college and will not be returned to me.

Applicant Signature ______________________________ **Date** ______________