

West Virginia University – Division of Occupational Therapy

VOLUNTEER/SHADOWING/EMPLOYMENT EXPERIENCE
IN OCCUPATIONAL THERAPY

VERIFICATION FORM

APPLICANT NAME: _____

NAME OF FACILITY: _____

FACILITY ADDRESS: _____

TYPE OF SETTING (e.g., Acute Care; School System; Skilled Nursing Facility, etc.):

DATES OF VOLUNTEERING/SHADOWING/EMPLOYMENT:

_____ to _____

**TOTAL NUMBER OF VOLUNTEER/SHADOWING/EMPLOYMENT HOURS AT THIS
FACILITY WITH THE THERAPIST BELOW: _____ HOURS**

DUTIES/ACTIVITIES OBSERVED:

NAME OF OCCUPATIONAL THERAPIST SUPERVISING YOUR EXPERIENCE:

SIGNATURE OF SUPERVISOR: _____

CREDENTIALS (e.g., OTR/L) _____

DATE: _____