Cox College MSOT
1423 N Jefferson Ave
Springfield MO 65802
417-269-3401

MSOT Program
Observation Verification Form

Applicant Name: _____

To be completed by the student applicant:

I spent _____ hours in this clinical setting in contact with an OTR.
I spent _____ hours in this clinical setting in contact with a professional other than an occupational therapist.

Supervisor's Name: _____ Profession: ___OTR ___COTA_____Other(list)
Facility: _____ Phone: ( )_____-_____
Address: _____ City: _____ State: _____ Zip: _____

Type of Setting: ___Inpatient ___Outpatient ___Home Health
___School ___Long Term Care ___Other:_____

Date(s) of Experience(s): _____

*By signing below, the student applicant attests that the above information is correct and true. Students please upload this signed form to your OTCAS application under additional documents. **15** hours are required.*

Applicant's Signature	Date

To be completed by the professional being observed:

By signing below, I attest that the student participated in observation of occupational therapy services for the date/s and amount of hours listed above. Please return the form to the student.

Therapist's Signature	Credentials	Date

Additional comments: