PRISMA HEALTH®

Pre-Therapy Observation Program

Documentation of Therapy Observation Hours

To be completed by the student and signed by the host therapist.		
Student Name:		
Type of Observation Experience: € Occupational Therapy € Physical Therapy € Recreational Therapy € Speech Therapy € Music Therapy € Art Therapy	**Setting:** € Acute € In-Patient € Out-Patient € Sub-Acute € Other: ________________________	
Facility Name:		
Start Date:	**End Date:**	**Total Hours:**
Therapy Host Name:		
Host Signature:		