



Georgia State Board of Occupational Therapy  
237 Coliseum Drive  
Macon, Georgia 31217-3858  
Telephone: (478) 207-2440  
<http://sos.ga.gov/index.php/licensing/plb/36>

## “FORM A”

**Note: Submit this form “only” if you are completing supervised clinical practice.**

### SUPERVISED CLINICAL EXPERIENCE (FORM A)

**Instructions:**

1. Please read AND refer to Board Rule 671-3-.09.

1. Applicant Name: \_\_\_\_\_
2. Agency Name: \_\_\_\_\_ Telephone No. (\_\_\_\_) \_\_\_\_\_
3. Agency Address: \_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City State Zip
4. Program Supervisor: \_\_\_\_\_ License No: \_\_\_\_\_

**Clinical Practice –Under Direct Supervision - Supervised Clinical Practice**, as used in the Law shall mean daily on-site, close contact whereby the supervisor is able to respond quickly to the needs of the client or supervisee. See Board Rules 671-2-.02 and 671-2-.03.

**The applicant must submit to the board for approval each of the following:**

1. A copy of the current valid license card of the licensed/certified Occupational Therapist who will supervise the clinical practice.
2. A calendar or outline of the supervised clinical practice and practice areas, including orientation, if applicable.

As Supervise Clinical Experience Coordinator, I agree that \_\_\_\_\_ (name of applicant) will complete 320 hours of supervised clinical experience which meets the requirements of an accredited or approved occupational therapy or occupational therapy assistant curriculum.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Supervisor **and “Active” OT License Number**

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Printed Name of Supervisor

\_\_\_\_\_  
Email address

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City State Zip