



## Designated Occupational Therapist OR Approved Supervisor Bi-monthly Report

Restricted licensee: \_\_\_\_\_

Contact telephone number: \_\_\_\_\_

Designated OT or approved supervisor: \_\_\_\_\_

Contact telephone number: \_\_\_\_\_

Bi-monthly report for the period (Month/Day/Year) of \_\_\_\_\_ to \_\_\_\_\_

1. Indicate the type of activities and contacts that have been made with the restricted licensee since the last report:
  - Telephone/e-mail/fax
  - Direct/virtual personal contact
  - Review of documentation
2. Were there any practice concerns that have arisen during this reporting period?  
 Yes  No If yes, please describe and explain the steps that have been taken to resolve these concerns (use additional pages if necessary):
3. Have these concerns been resolved?  Yes  No. If no, please comment.

Designated occupational therapist or approved supervisor

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Restricted licensee. I acknowledge that I have read and agree with the information in this report.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Additional Comments (if any):