



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):