

OCCUPATIONAL THERAPY

PHONE: () _____ FAX: () _____

WORK/SCHOOL NOTE

Patient: _____

Date: _____

This patient has been treated at our clinic on the following times:

Monday	_____ - _____
Tuesday	_____ - _____
Wednesday	_____ - _____
Thursday	_____ - _____
Friday	_____ - _____

If you have any questions, please feel free to contact us.

Therapist Signature: _____