



OTA CLINICAL SITE VISITOR FORM

(Please submit this form along with your time sheet for each pay period)

Employee Name: _____

DATE OF VISIT	TIME IN	TIME OUT	DESTINATION (SITE NAME)	SITE SUPERVISOR SIGNATURE
WEEK OF _____				
MONDAY -				
TUESDAY -				
WEDNESDAY -				
THURSDAY -				
FRIDAY -				
WEEK OF _____				
MONDAY -				
TUESDAY -				
WEDNESDAY -				
THURSDAY -				
FRIDAY -				

EMPLOYEE SIGNATURE _____

PROGRAM DIRECTOR SIGNATURE _____

DATE: _____