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| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Occupational Therapy Month

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| **Across**  **2.** Goal of OT  **8.** Used to put on socks  **9.** What month in OT month  **10.** What is your OT’s first name  **11.** Number of OT team members  **13.** Assists with mobility  **14.** What item helps you get your shoe on? | **Down**  **1.** Used to pick up items  **3.** Helps to button shirt and pants  **4.** Sat on to conserve energy while showering  **5.** Attaches to a plate to prevent food from falling off  **6.** Name of cup used to prevent spillage  **7.** Used when having difficulty tying shoes  **12.** What is your COTA’s first name |