

North Dakota State Board of Occupational Therapy Practice

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**Individual Licenseholder's Continued Competency
Attendance Form**

****This form is to be used ONLY if the program provider did not issue a certificate of completion! ****

[All incomplete forms will be returned causing a delay of your licensure renewal.]

Participant's License Number: _____

Participant's Name: _____

Participant's Address

Participant's E-mail: _____

Number of Contact Hours _____

Name of Program _____

Date(s) of Program _____

Location of Program City _____ State _____

Provider's Name _____

Contact Person _____ E-mail _____

I affirm the above continued competency contact hours have been successfully completed by the above named licensee.

Signature of Supervisor/Program Director

Date