NORTH DAKOTA STATE BOARD OF OCCUPATIONAL THERAPY PRACTICE

APPLICATION FOR RENEWAL OF LICENSE

2008 / 2010

OFFICE USE ONLY
Postmark Date _______________
Date Received _________________
Amount _______________________
Check # ______________________

MAIL RENEWAL, CHECK, & NDSBOTP
PO BOX 4005
BISMARCK, ND 58502-4005

MAKE CHECKS PAYABLE TO: NDSBOTP

☐ OT $150.00 ☐ OTA $110.00 LATE FEE $100.00 _______

INCLUDE LATE FEE IF APPLICATION, FEE, AND CONTINUING EDUCATION ARE NOT POST MARKED ON OR BEFORE JUNE 1ST.

LICENSE NO. ___________

NAME ____
FIRST MIDDLE LAST MAIDEN

HOME ADDRESS ____

____
CITY STATE ZIP COUNTY

HOME PHONE ____________________ WORK PHONE _________________________

E-MAIL __________________ PLACE OF EMPLOYMENT ________________________

WORK ADDRESS ____

____
CITY STATE ZIP COUNTY

AREA OF PRACTICE:

- ☐ Administration & Management (Private Practice)
- ☐ Developmental Disabilities
- ☐ Education
- ☐ Mental Health
- ☐ Gerontology
- ☐ Physical Disabilities (Hand therapy)
- ☐ School System
- ☐ Home & Community Health
- ☐ Technology
- ☐ Work Programs

PLEASE INDICATE IF ______ NAME _______ ADDRESS _________PLACE OF EMPLOYMENT HAVE BEEN CHANGED SINCE YOUR LAST RENEWAL.

Have you ever been sued for malpractice? ____ Yes ____No
Have you ever been convicted of an offense other than a minor traffic violation? ____Yes ____No
Have you ever been notified by a state occupational therapy board of any complaint against you relative to the practice of occupational therapy? ____Yes ____No
Has any state occupational therapy board ever denied, reprimanded, suspended or revoked a license issued to you? ____Yes ____No

IF THE ANSWER TO ANY OF THE QUESTIONS IS YES, PLEASE ATTACH A SEPARATE SHEET & GIVE COMPLETE DETAILS. IF THE DETAILS WERE PREVIOUSLY SUBMITTED, YOU DO NOT NEED TO SUBMIT THEM AGAIN.

OVER

ALL OCCUPATIONAL THERAPISTS AND OCCUPATIONAL THERAPY ASSISTANTS MUST SIGN BELOW OR THE APPLICATION WILL BE RETURNED!

I, being duly sworn, state that I am the person who is referred to in the foregoing application in the State of North Dakota, that the statements contained herein are strictly true in every respect and that I have read and understand this affidavit.

_______________________________ _______________

Signature of Applicant Date

ALL OCCUPATIONAL THERAPY ASSISTANTS MUST COMPLETE THE FOLLOWING!

SUBSTANTIATION OF SUPERVISION
OCCUPATIONAL THERAPY ASSISTANTS

SUPERVISION

The occupational therapist shall exercise appropriate supervision over persons who are authorized to practice only under the supervision of the licensed therapist. **No occupational therapist may supervise more than (3) three occupational therapy assistants at the same time providing that at least one of the occupational therapy assistants has five or more years of experience in occupational therapy.**

Please place an "X" to indicate your level of required supervision.

1. _____ Any entry-level occupational therapy assistant who has practiced occupational therapy 1650 hours or less, shall receive on site supervision from a licensed occupational therapist. The supervising occupational therapist must be on the premises during the occupational therapy assistant's occupational therapy work hours.
2. _____ The occupational therapy assistant with greater than one year (1650 hours) but less than five years of work experience in occupational therapy shall receive on-site supervision by a licensed occupational therapist a minimum of 2 hours per 40 occupational therapy work hours or 5% of the total occupational therapy work hours as a practicing occupational therapy assistant.
3. _____ The occupational therapy assistant with greater than five years of occupational therapy work experience must receive on-site supervision by a licensed occupational therapist at a minimum of one hour per 40 occupational therapy work hours or 2.5% of the total occupational therapy work hours.

I Certify that my supervision of this individual meets the requirements of the North Dakota State Board of Occupational Therapy Practice.

____

Printed name of OT Supervisor

____ _______________________

Signature of OT Supervisor Date

Rev. 02/08