

NORTH DAKOTA STATE BOARD OF OCCUPATIONAL THERAPY PRACTICE

APPLICATION FOR RENEWAL OF LICENSE

2010 / 2012

MAIL RENEWAL, CHECK, & EDUCATION TO: PO BOX 4005

NDSBOTP

BISMARCK, ND 58502-4005

MAKE CHECKS PAYABLE TO:

NDSBOTP

OFFICE USE ONLY

Postmark Date _____

Date Received _____

Amount _____

Check # _____

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 1, 2010.

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