

**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