



## MD BOARD OF OCCUPATIONAL THERAPY PRACTICE

Spring Grove Hospital Center • 55 Wade Avenue • Baltimore, MD 21228

410-402-8556 • 410-402-8561 (Fax)

<http://dhmh.maryland.gov/botp>

### LICENSE VERIFICATION REQUEST FORM

#### Instructions:

1. Online verification is available via the Board's website, [dhmh.maryland.gov/botp](http://dhmh.maryland.gov/botp). Select Verify a License.
2. If requesting a written verification from the Board, with Board seal affixed, complete items 1, **Requestor Information; and Recipient Information**
3. Enclose a \$20 check or money order payable to MBOT. Do not send cash.
4. Forward completed form and payment to: MBOT, 55 Wade Ave., Bland Bryant Bldg., 4<sup>th</sup> Floor, Baltimore, MD 21228

#### 1. REQUESTOR INFORMATION: (Please print)

First Name: \_\_\_\_\_ Street: \_\_\_\_\_  
Last Name: \_\_\_\_\_ City: \_\_\_\_\_  
Phone: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
License Number: \_\_\_\_\_  Occupational Therapist  Occupational Therapy Assistant  
Email address: \_\_\_\_\_  
Name when originally licensed: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### 2. RECIPIENT INFORMATION: (Please print)

Delivery Options: \_\_\_\_\_ U.S. Mail \_\_\_\_\_ Email \_\_\_\_\_ Fax \_\_\_\_\_  
Name: \_\_\_\_\_  
Company/Organization: \_\_\_\_\_  
Street: \_\_\_\_\_ P.O. Box: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Email: \_\_\_\_\_ Fax: \_\_\_\_\_ Phone: \_\_\_\_\_