MARYLAND BOARD OF OCCUPATIONAL THERAPY
SPRING GROVE HOSPITAL • BLAND BRYANT BUILDING, 4TH FLOOR
55 WADE AVENUE • BALTIMORE, MARYLAND 21228
Phone 410-402-8560 • Fax 410-402-8561 • www.dhmh.maryland.gov/botp

CHANGE OF INFORMATION REQUEST

Per COMAR 10.46.01.02, an applicant or licensee shall report a change of electronic mail address, postal address, or change of name, in writing, within 30 days of the change. The Board must, by law, have a valid address/name for you. The address/name that you provide is the "address/name of record" that is available for public information requests. Please provide a full mailing address, electronic address and phone number at which you can be reached during the day. The Board is authorized to proceed with its duties, including discipline, after it has attempted to contact you at the address of record, with or without your participation. Failure to notify the Board of an address/name change may result in your failure to receive a renewal application, which may in turn lead to disciplinary action for practicing on an expired license. Untimely notification to the Board of information changes may result in a late fee of $50.

Name:	License Number:

Notice for Mailing Lists

The information collected is for the purpose of licensure under the Maryland Health Occupations Annotated Code, Title 10. You have the right to inspect, amend and correct this information. The Board may permit inspection of this information, or make it available to others, only as permitted by Federal and State law. The Board may sell or provide a list of licensees' names and addresses to professional associations and other entities. Under the Maryland Public Information Act, Maryland State Government Code Annotated §10-617, you may request in writing that your name be omitted from such lists.

PLEASE DARKEN THE APPROPRIATE BOX

What information has changed?

☐ Name ☐ Home Address ☐ E-mail Address ☐ Home Phone ☐ Work Phone

NAME CHANGE

Previous Name:	New Name:

A change of name requires substantiating documentation, i.e., a marriage certificate, divorce decree, etc.

ADDRESS CHANGE

Old Mailing Address	New Mailing Address
Street:	Street:
City:	City:
State: Zip:	State: Zip:

PHONE NUMBER CHANGE

Home Number	Work Number
Old:	Old:
New:	New:

E-MAIL ADDRESS CHANGE

New E-mail Address:

I affirm that the contents of this document are true and correct to the best of my knowledge and belief. Further, I authorize the Board to update their records to reflect this information.

☐ **I am moving out of state and will not be practicing in MD. (Please note the Board is required to send a notice of renewal to the last known electronic or physical address of each active licensee. Mailings thereafter will be discontinued.)**

Signature: _____ Date: _____

For Office Use:

Date Received: _____ Date Processed: _____