

Application for Licensure

Maryland Board of Occupational Therapy Practice

Instructions:

1. Write answers in ALL CAPS.
2. Use black or blue ink.
3. Answer ALL questions (1-30) completely and accurately.
4. ENCLOSE APPLICABLE FEE.

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

Spring Grove Hospital Center ♦ 55 Wade Avenue
 Bland Bryant Building, 4th Floor ♦ Baltimore, MD 21228
 Phone: 410-402-8560 ♦ Fax: 410-402-8561
 TDD for Disabled: Maryland Relay Service 1-800-735-2258

Personal Profile

1. Last Name:

2. First Name and Middle Initial:

3. Type(s) of License sought:
 Official License: OT OTA
 Temporary License: OT OTA
 (exam candidates only)
 Reinstatement: OT OTA
 Reactivation: OT OTA

4. Social Security Number: - -

5. Gender: Male Female

6. Date of Birth: / /

7. Please check all that apply: Ethnicity: American Indian or Alaska Native Asian Black or African American
 Hispanic or Latino Native Hawaiian or other Pacific Islands White Other

8. Address:

8a. Apt. Number (indicate APT in first three boxes): OR 8b. In care of (if applicable):

9. City: 10. State: 11. Zip Code:

12. Country: 13. Professional Email Address:

14. Primary Phone: - - 15. Secondary Phone: - -

16. Alias (Maiden Name, etc.): 17. Date of Alias Change: / /

Discipline		Certification
18. Are you or have you ever:		20. Verification of initial NBCOT certification is required.
a. been convicted of a misdemeanor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	a. NBCOT Certification # _____
b. been convicted of a felony?	<input type="checkbox"/> Yes <input type="checkbox"/> No	b. Initial Certification Date: _____
c. had any disciplinary action taken against your license in any state or country?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>NBCOT Verification must be provided to the Board from NBCOT.</i>
d. been addicted to the use of drugs or alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	21. Occupational Therapy Education:
e. had a physical or mental illness that impairs your ability to practice your profession?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of School: _____
f. had a malpractice suit filed against you or damages been settled or awarded against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Month/Year of Graduation: _____ City: _____ State: _____
g. had any hospital or employer denied you privileges or employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Area of Practice/Specialty: _____
19. Are there any outstanding complaints, investigations or charges pending against you in any state?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p><i>If you answered yes to any of the questions above, a complete explanation and a certified copy of the court documents of your conviction(s) must be submitted for review. Photocopies will not be acceptable.</i></p>		

For Board Office Use Only

Approved by: _____

Date of Temporary License: _____

Date of Official License: _____

Continued on back

LAST NAME:

FIRST NAME:

Licensure

22. Have you ever been licensed in occupational therapy by the State of Maryland? Yes No
 If yes, License # _____
23. Are you, or have you ever been, licensed to practice occupational therapy in another state or country? Yes No
 If yes, please list _____
(Verification of licensure must be provided to the Board from each state or country.)

Military Experience

24. a. Are you active duty military, including reservists called to active duty for training or deployment? Yes No
 b. Are you a military veteran discharged within one year of this licensing application? Yes No
 If yes, date of discharge: _____
 c. Are you the spouse of an active duty military or recently discharged veteran? Yes No

Educational Experience

25. Has it been more than one year since you graduated from an Occupational Therapy academic program? Yes* No
 *If yes, per COMAR 10.46.04, please indicate:
- a. I attest to maintaining current certification with NBCOT which fulfills the MD State Continuing Competency requirement; OR
 b. I do not maintain current certification with NBCOT, and I am providing documentation for 12 contact hours and a completed Continuing Competency Requirement Compliance Report.

Professional Experience

26. Has there been a lapse of three years or more since you have practiced occupational therapy? Yes No
(If yes, please see COMAR 10.46.04.04 C (3) for additional requirements.)

Signature/Affirmation

- 27.
- a. The contents of this document are true and correct to the best of my knowledge and belief. Yes No
- b. I have read and understand the Annotated Code of Maryland Health Occupations Article Title 10, and the Code of Maryland Regulations (COMAR) 10.46, Maryland Board of Occupational Therapy Practice. Yes No
- c. I have knowingly practiced Occupational Therapy in Maryland without a valid Maryland license. Yes No

This space is to contain a recent passport type full-face photograph of the applicant.

Photograph must be securely taped in place.

Newspaper photographs, etc., are not acceptable.

PLEASE DO NOT STAPLE.

Failure to provide accurate information may result in denial of licensure.

28. APPLICANT'S SIGNATURE (REQUIRED):

29. DATE:

30. NOTARY PUBLIC:

Sworn before me this (Date) _____

Expiration Date _____



Signature Notary Public

Applicant Fee: \$200.00
Reinstatement Fee: \$225.00
Reactivation Fee: \$123.00
Do not staple fee payment to form.

Make check or money order payable to "MBOT". Cash or credit card cannot be accepted. If the application is not complete per regulation 10.46.01.02 C, the application may be destroyed. To reapply, a new application may need to be filed and another fee paid.

FEE IS NOT REFUNDABLE.