



# State of Ohio

Occupational Therapy, Physical Therapy, and Athletic Trainers Board  
Occupational Therapy Section

## Occupational Therapy Reinstatement Application Instructions

The reinstatement application applies to any individual who previously held a license to practice as an occupational therapist or occupational therapy assistant in Ohio at any time. Please review rule 4755-3-12 of the Ohio Administrative Code for clarification on the requirements to apply to reinstate your Ohio occupational therapist/occupational therapy assistant license.

Applications are reviewed on a weekly basis. All applications must be **FULLY** completed before they are reviewed and a license is reinstated. If your application remains incomplete for one year from the date the Board receives it, your file will be closed.

The Occupational Therapy Section may require the following: (1) appearance before the Section for a reinstatement interview; (2) taking or re-taking the NBCOT certification examination; and/or (3) completion of refresher coursework. You will be notified of any additional requirements after the Section reviews your application.

Each reinstatement applicant must demonstrate proof of CE completion. Any continuing education credits used to reinstate your license to active status may not be used to fulfill the continuing education renewal requirements.

You may not practice occupational therapy in Ohio until your license is reinstated.

### To reinstate your Ohio license, you must complete all of the following:

*(This form and instruction sheet is for your personal records.)*

<p><b><u>Application Fee</u></b></p> <p><input type="checkbox"/> The application fee is non-refundable. Please submit a cashier's check, business check, or money order made payable to "Treasurer State of Ohio" for \$150.00. Personal checks, cash, and/or credit cards will not be accepted.</p>
<p><b><u>Photograph</u></b></p> <p><input type="checkbox"/> Please staple a passport photograph of your face taken within the six month period immediately preceding the date of your application. The photo should be 2 x 2 inches in size. If the photo is digital, it must be a clear representation and must meet the specifications listed above. For more information please review the <i>Passport Photograph Guidelines</i> on the Board's website (<a href="http://otptat.ohio.gov">http://otptat.ohio.gov</a>).</p>
<p><b><u>Jurisprudence Examination</u></b></p> <p><input type="checkbox"/> You must score a 90% or better to pass the examination. Please download the Ohio Occupational Therapy Laws and Rules and licensure law test from the Board website.</p>
<p><b><u>Notarized Statement</u></b></p> <p><input type="checkbox"/> You must submit a notarized statement indicating why you did not renew your license by the prescribed renewal date or why you would like to reinstate your Ohio license.</p>
<p><b><u>Verification of Licensure</u></b></p> <p><input type="checkbox"/> You must provide a verification from any state in which you currently hold or have ever held a license to practice occupational therapy or another healthcare profession.</p>
<p><b><u>Continuing Education</u></b></p> <p><input type="checkbox"/> You must provide proof of completion of 20 hours of CE, including one hour of ethics, completed in the two years prior to the date you submit this reinstatement application. Please provide copies of your certificates of completion.</p>



## State of Ohio

Occupational Therapy, Physical Therapy, and Athletic Trainers Board  
Occupational Therapy Section

### Occupational Therapy Reinstatement Application Instructions

Original certificates will not be returned.

#### Employment History Form

- You must complete and sign the employment history form.

#### **Additional Requirements For Individuals Who Have Not Practiced Occupational Therapy**

##### **For Five Or More Years Prior to the Date of This Application:**

Applicants applying for licensure by reinstatement who have not engaged in the practice of occupational therapy for more than five years prior to the date the individual applies to the Section for licensure by reinstatement may be subject to additional requirements including, but not limited to: (1) Submission of proof of completion of twenty hours of continuing education within the two year period immediately preceding the date the application is submitted; (2) Professional development plan; (3) Extended coursework; (4) Retaking and passing the NBCOT certification examination; (5) Mentorship; and (6) Competency-based performance appraisals.



**The Occupational Therapy Section**

Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board  
 77 South High Street, 16th Floor  
 Columbus, Ohio 43215-6108

Phone (614) 466-3774 Fax (614) 995-0816  
 Website: <http://otptat.ohio.gov>  
 Email: [board@otptat.ohio.gov](mailto:board@otptat.ohio.gov)

APPLICATION FOR LICENSE TO PRACTICE OCCUPATIONAL THERAPY IN OHIO	
<b>Profession</b> (Select one)	
<input type="radio"/>	Occupational Therapist
<input type="radio"/>	Occupational Therapy Assistant
<b>Application Type</b> (Select one)	
<input type="radio"/>	Examination
<input type="radio"/>	Endorsement
<input type="radio"/>	Reinstatement
<input type="radio"/>	Limited Permit
<input type="radio"/>	Restoration

**INSTRUCTIONS, PLEASE READ:**

- A. Complete all relevant categories (type or print in ink).
- B. Photo must be submitted with this application.
- C. Fee must be submitted with application. (**Money Order/Cashier's Check** must be made payable to "**Treasurer State of Ohio**")

**ALL LICENSURE APPLICATION FEES ARE NON-REFUNDABLE**

\*\*PLEASE READ: Provision of your social security number is mandatory and may be provided for child support enforcement purposes (ORC 3123.50) and for reporting requirements to the Federal Healthcare and Integrity Protection Data Bank (42 USC 132a-7e, 5 USC 552a, 45CFR pt. 61). In compliance with section 1347.05 (E) of the Revised Code, you are notified that failure to supply the information requested in this application may result in a denial of the application.

Section A: IDENTIFICATION INFORMATION					
First Name		Middle Name	Last Name		Maiden Name
Home Phone Number (with Area Code)			Work or Alternate Phone Number (with Area Code)		
Permanent Mailing Address					
City		State	Zip	County	
**Social Security Number		Email Address (Optional)			
Date Of Birth (mm/dd/yyyy)			Place Of Birth (City and State)		
Color of Hair	Color of Eyes	Weight	Height	Gender <input type="radio"/> Male <input type="radio"/> Female	
According to rule 4755-3-08 of the Ohio Administrative Code, you must inform the Occupational Therapy Section in writing of any change of name, address, or employment within thirty days after the change.					

**Staple Passport Photograph Here**

Photograph must be 2 x 2 inches in size, full face, front view, between 1 inch and 1 3/8 inches from the bottom of the chin to the top of the head. Background color white, off-white, or light blue. Photograph must be taken with the past 6 months. Sign back of photograph.

FOR OFFICE USE ONLY
Application Received
Amount \$:
Money Order #:
Batch Number

**Section B: EDUCATION**

**Entry Level Occupational Therapy Education**

Name and Location (City, State)	Certificate/ Degree	Dates Attended (MO/YR)	
		From	To

**Other Post High School Education**

Please list all post-professional education and/or other colleges attended.

Name and Location (City, State)	Certificate/ Degree	Dates Attended (MO/YR)	
		From	To

**Section C: EXPERIENCE**

(Starting with present position, list chronologically your work experience during the past ten years. Limited Permit and Examination Applicants must list their field work experience. Please attach a separate page if necessary.)

DATES (MO/YR)		JOB TITLE, TYPE OF PRACTICE AND AVERAGE WORK HOURS PER WEEK	NAME AND ADDRESS OF EMPLOYER	PERFORMED OT DUTIES IN OHIO	
Start	End			YES	NO

**Section E: LICENSURE HISTORY**

Do you currently hold or have ever held a license, limited permit, certification, or registration to practice occupational therapy or another healthcare profession in this state and/or another state.  YES  NO

If YES, Please complete the table below.

Initial license to practice as an  Occupational Therapist  Occupational Therapy Assistant issued by which State?

STATE	LICENSE # / LIMITED PERMIT #	ISSUE DATE	EXPIRATION DATE

**Section F: BACKGROUND QUESTIONS**

Answer the following questions by initialing in the appropriate space at the right.

NOTE: Be advised that you are under a continuing obligation to supplement your answers to these questions should any answers change following the submission of this application.

	YES	NO
1. Have you ever been convicted of, found guilty of, pled guilty to or received treatment in lieu of conviction for a felony and/or any offense involving moral turpitude in Ohio, another state, or a US territory?		
2. Have you ever been adjudged by a court, in Ohio, another state, or a US territory to be incompetent?		
3. Have you ever been denied licensure to practice as an occupational therapist or occupational therapy assistant, or another healthcare profession in Ohio, another state, or US territory?		
4. Have you ever been disciplined in any state or US territory in which you have ever held a license to practice as an occupational therapist or occupational therapy assistant, or any other healthcare profession?		
5. Have you used drugs, narcotics, or alcohol to the extent that it impairs you ability to practice occupational therapy or another healthcare profession?		
6. Have you ever been convicted of a misdemeanor when the act that constituted the misdemeanor occurred during the practice of occupational therapy?		

If the answer to any questions is "yes", please provide a written statement explaining the incident(s) and what state it occurred in and attach supporting documentation including but not limited to: *court records, police records, and/or documentation from other state licensing boards.* . If you have been convicted of a felony, you must provide "certified "copies of the following court documents: *Indictment, Plea Entry, Disposition, Sentencing Entry, Terms of Parole or Probation, Parole or Probation and Release/Discharge*

---



---



---



---

**SECTION G: ANTICIPATED PLACE OF EMPLOYMENT**

If unknown at the time this application is completed, please put "Unknown")

Facility Name	Employment Starting Date
Facility Physical Address (include City, State, and Zip)	Title/Position
Name of Supervising Occupational Therapist	License Number
	Phone Number w/Area Code

**SECTION H: CERTIFICATION OF APPLICANT**

**The section must be sworn to in the presence of a Notary Public or an officer authorized to administer oaths.**

I, \_\_\_\_\_, certify that I am the person referred to in this application and that the foregoing statements are true in every respect, and that the attached photograph is a true likeness of myself.

I hereby authorize all my references; educational institutions; employers; business; professional organizations and associates - past, present, and future- to release to the Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board any information requested by the Board in connection with the processing of this application or subsequent licensure.

In accordance with the Revised Code, section 1347.05(E) you are notified that failure to supply the information requested on the application may result in denial of the application.

I hereby certify to the Occupational Therapy Section that I am not presently functioning and will not function as an Occupational Therapist or Occupational Therapy Assistant or use any titles or initials to indicate or imply that I am licensed in Ohio to perform occupational therapy services until I receive a full license or limited permit from the OT/PT/AT Board.

I further certify that if I accept employment as an OT/OTA, or limited permit holder (a category for recent graduates who have not yet taken the NBCOT Examination), I will only perform duties in accordance with the laws and rules governing occupational therapy practice in the State of Ohio.

I understand the Board is authorized to investigate persons whom they have reason to believe are unlawfully practicing occupational therapy.

I further understand that pursuant to section 4755.11 of the Ohio Revised Code, the Occupational Therapy Section may suspend, revoke, or refuse to issue or renew the license of an individual who has violated any of the laws and rules governing occupational therapy in the State of Ohio.

If I am applying for a limited permit, I hereby certify that I understand that my limited permit will be valid for four (4) months from the date of issue, or when the Section receives the results of my NBCOT examination, *whichever occurs first*. I also understand that my limited permit will immediately expire if I fail the NBCOT examination. If I fail the NBCOT examination, I shall notify my employer and must immediately cease performing as a limited permit holder.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**SECTION I: Notary Public please complete the following:**

Subscribed and sworn to in my presence this \_\_\_\_\_ day of \_\_\_\_\_, Year \_\_\_\_\_.

\_\_\_\_\_  
Signature of Notary

\_\_\_\_\_  
Date Commission Expires

**Return This Document To:**

Ohio OT PT AT Board  
77 South High Street, 16<sup>th</sup> Floor  
Columbus, OH 43215-6108

*Notary Seal*





# State of Ohio

Occupational Therapy, Physical Therapy, and Athletic Trainers Board

## Occupational Therapy Continuing Education Reporting Form

Full Name \_\_\_\_\_

License Number: OT/OTA \_\_\_\_\_

- A. Presentations of occupational therapy programs, workshops, or seminars
- B. Preparation to teach a clinical course in occupational therapy
- C. Supervision of fieldwork

(A maximum of 8 hours may be earned in each of these categories)

Name of Course/Activity	Date	# of Hours

### Research Projects

(A maximum of 10 hours may be earned in this category)

Name of Research Project/Activity	Date	# of Hours

### Informal Independent Study

(A maximum of 4 hours may be earned in this category)

Name of Informal Independent Study/Activity	Date	# of Hours

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

Return This Document To:  
Ohio OT PT AT Board  
77 South High Street, 16<sup>th</sup> Floor  
Columbus, OH 43215-6108  
(614) 995-0816 (Fax)



# State of Ohio

Occupational Therapy, Physical Therapy, and Athletic Trainers Board

## Verification of Licensure

This form must be completed by an official from each state where the applicant currently holds or has ever held a license to practice an occupational health profession. You may copy this form and forward it as needed. Please contact each state directly to determine their license verification process.

<b>This section must be completed by the applicant. Please print or type.</b>		
Name (First, Middle, Last):	Maiden Name:	
Name as it appears on this state's license, certificate, registration, or permit:		
Type of License/Certificate/Registration/Permit: <input type="radio"/> OT <input type="radio"/> OTA <input type="radio"/> PT <input type="radio"/> PTA <input type="radio"/> AT <input type="radio"/> Other _____	State	License Number
Social Security Number:	Date of Birth (mm/dd/yyyy):	

**The Ohio OT PT AT Board requests that I submit evidence of my license/certification/registration/permit in your state. You are hereby authorized to release any information in your possession pertaining to me directly to the Ohio OT PT AT Board, 77 South High Street, 16<sup>th</sup> Floor, Columbus, Ohio, 43215-6108.**

\_\_\_\_\_  
Applicant Signature \_\_\_\_\_  
Date

<b>This section must be completed by an administrative officer of the regulatory agency. Please print or type.</b>			
State of Licensure:	License Number:	Original Issue Date:	Expiration Date:
Current Licensure Status: <input type="radio"/> Active <input type="radio"/> Inactive/Expired <input type="radio"/> Suspended/Revoked <input type="radio"/> Other (Explain)			
The license was issued on the basis of: <input type="radio"/> Examination <input type="radio"/> Endorsement <input type="radio"/> NBCOT or BOC <input type="radio"/> Grandfather <input type="radio"/> Other (Explain)			
Has the applicant's license to practice ever been restricted or disciplined in any way? If yes, please explain and attach any relevant documentation.			
Does the applicant have any pending complaints or is the applicant currently under investigation? If yes, please explain and attach any relevant documentation.			

\_\_\_\_\_  
Print Name \_\_\_\_\_  
Title

\_\_\_\_\_  
Signature \_\_\_\_\_  
Date

**Return This Document To:**  
 Ohio OT PT AT Board  
 77 South High Street, 16<sup>th</sup> Floor  
 Columbus, OH 43215-6108

*Board Seal*



# State of Ohio

Occupational Therapy, Physical Therapy, and Athletic Trainers Board

## Employment History

This form must be completed by any person who is applying to reinstate an Ohio license. Attach additional sheets if necessary.

### Section A

1. Have you worked as an OT, OTA, PT, PTA, or AT in Ohio since the license you are applying to reinstate expired? <input type="radio"/> Yes <input type="radio"/> No
2. During this time period, were you employed by a contract company/agency? <input type="radio"/> Yes (If yes, complete sections B, C, and D.) <input type="radio"/> No (If no, complete sections C and D.)
3. What type of license are you applying to reinstate? (Please provide Ohio license number) <input type="radio"/> OT # <input type="radio"/> OTA # <input type="radio"/> PT # <input type="radio"/> PTA # <input type="radio"/> AT #

### Section B

*If you were employed with a contract company/agency, you are required to list the details for each facility in Ohio where you provided OT, OTA, PT, PTA, or AT services, including the name of each person who supervised you and the dates you provided services at each facility.*

Name of Contract Company/Agency:	
Address, City, State, Zip Code:	
Phone Number w/ Area Code:	Supervisor's Name, Title, License Number (If Applicable):
Supervisor's e-mail address:	

### Section C

#### Employment Information

<b>Employer #1:</b> (Company Name)	
Address, City, State, Zip Code:	
Phone Number w/ Area Code:	Supervisor's Name, Title, License Number (If Applicable):
Supervisor's e-mail address:	
List the specific date(s) you provided services at this facility:	



# State of Ohio

Occupational Therapy, Physical Therapy, and Athletic Trainers Board

## Employment History

<b>Employer #2: (Company Name)</b>	
Address, City, State, Zip Code:	
Phone Number w/ Area Code:	Supervisor's Name, Title, License Number (If Applicable):
Supervisor's e-mail address:	
List the specific date(s) you provided services at this facility:	

<b>Employer #3: (Company Name)</b>	
Address, City, State, Zip Code:	
Phone Number w/ Area Code:	Supervisor's Name, Title, License Number (If Applicable):
Supervisor's e-mail address:	
List the specific date(s) you provided services at this facility:	

### Section D

I, the undersigned, hereby certify that the information provided on the employment history form is accurate to the best of my knowledge.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Type of License (OT, OTA, PT, PTA, AT)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Return This Document To:  
Ohio OT PT AT Board  
77 South High Street, 16<sup>th</sup> Floor  
Columbus, OH 43215-6108