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.)

Application Fee

- ❑ 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.

Photograph

- ❑ 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 *Passport Photograph Guidelines* on the Board's website (http://otptat.ohio.gov).

Jurisprudence Examination

- ❑ 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.

Notarized Statement

- ❑ 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.

Verification of Licensure

- ❑ 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.

Continuing Education

- ❑ 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.

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

APPLICATION FOR LICENSE TO PRACTICE OCCUPATIONAL THERAPY IN OHIO

Profession (Select one)
- ○ Occupational Therapist
- ○ Occupational Therapy Assistant

Application Type (Select one)
- ○ Examination
- ○ Endorsement
- ○ Reinstatement
- ○ Limited Permit
- ○ 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** ○ Male ○ 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.			

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

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.

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**
				YES	**NO**
				YES	**NO**
				YES	**NO**
				YES	**NO**
				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, 16th Floor
Columbus, OH 43215-6108

Notary Seal

State of Ohio

Occupational Therapy, Physical Therapy, and Athletic Trainers Board

Occupational Therapy
Continuing Education Reporting Form

This continuing education reporting form must be completed by any person who is applying to reinstate or restore an Ohio license. Occupational Therapist and Occupational therapy assistants are required to complete a minimum of 20 contact hours. Continuing education activities must be fulfilled for the two year period immediately preceding the date the Board receives the reinstatement application. Please provide **copies** of your certificates of completion. Original certificates will not be returned. If necessary, please attach an additional sheet of paper.

Full Name _____ **License Number: OT/OTA**_____

Ethics (At least 1 hour is REQUIRED)

Name of Ethics Course/Activity	Date	# of Hours

A. Attending professional workshops, seminars and/or conferences
B. Publications of books, articles or films
C. Undergraduate or graduate courses
D. Distance learning
E. Apprenticeships
F. Self study
(There are NO maximums for any of these categories)

Name of Course/Activity	Date	# of Hours

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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

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Ohio OT PT AT Board
77 South High Street, 16th 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 jurisdiction where the applicant currently holds or has ever held a license, certification, or registration to practice an occupational health profession. Jurisdiction means any state, U.S. territory, or foreign country. You may copy this form and forward it as needed. Please contact each state directly to determine their license verification process.

This section must be completed by the applicant. Please print or type.		
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: ○ OT ○ OTA ○ PT ○ PTA ○ AT ○ Other _____	Jurisdiction	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 jurisdiction. 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, 16th Floor, Columbus, Ohio, 43215-6108.

Applicant Signature _____ Date _____

This section must be completed by an administrative officer of the regulatory agency. Please print or type.			
Licensure Jurisdiction:	License Number:	Original Issue Date:	Expiration Date:
Current Licensure Status: ○ Active ○ Inactive/Expired ○ Suspended/Revoked ○ Other (Explain)			
The license was issued on the basis of: ○ Examination ○ Endorsement ○ NBCOT or BOC ○ Grandfather ○ 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, 16th Floor
Columbus, OH 43215-6108

Board Seal

State of Ohio

Occupational Therapy, Physical Therapy, and Athletic Trainers Board

Employment History
This form is MANDATORY for Reinstatement Applicants

This form must be completed by any person who is applying to reinstate an Ohio license. Attach additional sheets if necessary. **If this form is not complete in its entirety, your application will not be processed and this form will be returned to you for completion.**

Section A

1. What type of license are you applying to reinstate? (Please provide Ohio license number)

   ○ OT #_____ ○ PT # _____ ○ AT # _____

   ○ OTA # _____ ○ PTA # _____

2. When did you discover your license expired (please list a specific date)?

3. How did you discover your license expired?

   ○ Board letter ○ Employer discovered ○ Other, Explain

4. Have you any provided treatments to patients/clients as an OT, OTA, PT, PTA, or AT **in Ohio** since your license expired?

   ○ Yes ○ No

5. If "yes" to question 4, were you employed by a contract company/agency?

   ○ Yes (If yes, complete sections B, C, and D.) ○ No (If no, complete sections C and D.)

Section B

If you were employed by 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(s):

Section C

*Employment Information**-***If you worked for a contract company, list the facility(s) where you provided services in this section.***

Employer #1: (Company or Facility Name)	
Address, City, State, Zip Code:	
Phone Number w/ Area Code:	Supervisor(s) Name, Title, License Number(s):
List the specific date(s) you provided services at this facility ***(Only list the dates you practiced at this facility after your licensed expired)**:	

State of Ohio

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Employment History
This form is MANDATORY for Reinstatement Applicants

Employer #2: (Company or Facility Name)	
Address, City, State, Zip Code:	
Phone Number w/ Area Code:	Supervisor(s) Name, Title, License Number(s):
List the specific date(s) you provided services at this facility ***(Only list the dates you practiced at this facility <u>after your licensed expired</u>)**:	

Employer #3: (Company or Facility Name)	
Address, City, State, Zip Code:	
Phone Number w/ Area Code:	Supervisor(s) Name, Title, License Number(s):
List the specific date(s) you provided services at this facility ***(Only list the dates you practiced at this facility <u>after your licensed expired</u>)**:	

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, 16th Floor
Columbus, OH 43215-6108