Application for Licensure as an Occupational Therapist or Occupational Therapy Assistant

Board of Occupational Therapy
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: www.floridasoccupationaltherapy.gov
Email: info@floridasoccupationaltherapy.gov
Phone: (850) 245-4373
FAX: (850) 414-6860

Florida HEALTH
Medical Quality Assurance

Are you an active duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered “Yes” to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health’s commitment to serving members and veterans of the United States Armed Forces and their families online at

http://www.flhealthsource.gov/valor

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Do Not Write in this Space
For Revenue Receipting Only

Apply to the National Board for Certification in Occupational Therapy (NBCOT) to schedule the required licensure examination at www.nbcot.org or call (301) 990-7979.

Select one application type:

☐ Occupational Therapist (OT) (5601) **$180.00**
☐ Occupational Therapy Assistant (OTA) (5602) **$180.00**

Total fee of $180.00 includes the following:

Application Fee	$100.00
Licensure Fee	$75.00
Unlicensed Activity Fee	$5.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. An applicant who is denied licensure or withdraws their application is entitled to a $80.00 (Licensure Fee and Unlicensed Activity Fee) refund. Requests to withdraw or for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

Select one method of licensure: ☐ Endorsement (1021) (holds an **active** NBCOT Certification)
☐ Exam with Waiver (1024) (holds inactive/non-renewed NBCOT Certification **and** an active OT/OTA license in another state)
☐ Examination (1010) (has scheduled the NBCOT exam)

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone (Input without dashes)

Practice Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website)

_____ _____ _____
Street Suite No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone (Input without dashes)

EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part, 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: ☐ Male ☐ Female

Race: ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ Two or More Races ☐ Hispanic or Latino ☐ Black or African American ☐ White ☐ Asian

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

☐ Yes ☐ No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes (F.S.), authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

Social Security Number: _____
(Input without dashes)

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, F.S. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

You may apply for licensure before obtaining a Social Security number. However, you will not be issued a license until proof of a U.S. Social Security number is received.

3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

_____

B. Have you ever applied for an occupational therapist or occupational therapy assistant license in the state of Florida? ☐ Yes ☐ No

If "Yes," indicate the date you previously applied: _____
MM/DD/YYYY

C. Do you hold, or have you ever held a temporary permit, license/certification, or other authorization, regardless of status, to practice occupational therapy or **any health-related profession** in any state (**including Florida**), U.S. territory, or foreign country? ☐ Yes ☐ No

D. List all health-related licenses (active, inactive or lapsed).

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

☐ Board staff will attempt to complete verifications online for states that include disciplinary history. If the disciplinary history information is not available online, you will be required to request an official verification. License verifications must be received directly from the licensing authority regardless of the status of the license. **A copy of your license will not be accepted** in lieu of official verification from the licensing agency.

NBCOT maintains a list of all state regulatory entities with contact information on their website at www.nbcot.org.

4. DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? ☐ Yes ☐ No

Name: _____

5. EDUCATION HISTORY

A. List school, colleges, and universities attended.

School Name	Graduation Date (MM/DD/YYYY)	Degree Awarded

All applicants must have graduated from an accredited OT or OTA program accredited by the American Occupation Therapy Association (AOTA) to qualify for licensure.

B. What name(s) did you use when you received your occupational therapy education?

_____

6. EXAMINATION HISTORY

Have you taken the NBCOT (formerly AOTA or AOTCB) examination? ☐ Yes ☐ No

If "Yes," provide your NBCOT Certification Number: _____ *

** If uncertain, verify your number at* www.nbcot.org

☐ Board staff will attempt to verify your certification online. If verification is unavailable, you will be required to request that certification letter be sent to the board directly from NBCOT.

If "No," contact the NBCOT at (301) 990-7979 to schedule and complete the examination requirement. **A license cannot be issued until the NBCOT examination has been passed.**

There is a separate fee for the examination payable to the NBCOT.

Once you have registered for the examination, an Authorization to Test (ATT) letter will be sent by NBCOT. The ATT will include instructions to contact the testing vendor to schedule an examination date.

Name: _____

This information is exempt from public records disclosure.

7. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? ☐ Yes ☐ No

Substance-Related Disorders Impacting Ability to Practice

C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse? ☐ Yes ☐ No

E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? ☐ Yes ☐ No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

☐ **A letter from a Licensed Health Care Practitioner,** who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

☐ **A written self-explanation,** identifying the medical condition(s) or occurrence(s); and current status

Name: _____

8. DISCIPLINE HISTORY

A. Have you ever had a license to practice any profession revoked, suspended, or otherwise acted against in a disciplinary proceeding in any state? ☐ Yes ☐ No

B. Have you ever been disciplined, terminated or allowed to resign, in lieu of termination, from an employment setting where employed as an occupational therapist or occupational therapy assistant, or in any capacity in any other profession? ☐ Yes ☐ No

C. Have you ever been found guilty of malpractice? ☐ Yes ☐ No

D. Are you now under investigation in any jurisdiction for an offense, which would be a violation of ch. 456 or ch. 468, Part III, F.S. or Rule chapter 64B11, Florida Administrative Code (F.A.C.)? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

☐ A copy of the **Administrative Complaint** and **Final Order**.

9. CRIMINAL HISTORY

A. Have you ever been convicted or found guilty, regardless of adjudication, of a crime in any jurisdiction which directly relates to the practice of occupational therapy? ☐ Yes ☐ No

B. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld.

Reckless driving, driving while license suspended or revoked (DWSLR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question. ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, you must provide the following:

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" in this section, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.

☐ **Final Dispositions** and **Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

☐ **Completion of Sentence Documents**. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

Name: _____

10. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), F.S.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under ch. 409, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 893, F.S. (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 2.

   a. If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

   b. If "Yes" to 1, for the felonies of the third degree, has it been more than ten years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), F.S.)? ☐ Yes ☐ No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

   d. If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed (if "Yes," provide supporting documentation)? ☐ Yes ☐ No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 3.

   a. If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? ☐ Yes ☐ No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, F.S.? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 4.

   a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? ☐ Yes ☐ No

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 5.

   a. Have you been in good standing with a state Medicaid program for the most recent five years? ☐ Yes ☐ No

   b. Did termination occur at least 20 years before the date of this application? ☐ Yes ☐ No

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? ☐ Yes ☐ No

   a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? ☐ Yes ☐ No

   b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written explanation** for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation.

☐ **Supporting documentation** including court dispositions or agency orders where applicable.

All documentation must be submitted to info@floridasoccupationaltherapy.gov or mailed to:

Board *of* Occupational Therapy
4052 Bald Cypress Way Bin C-05
Tallahassee, FL 32399-3255

11. APPLICANTS SEEKING RE-ENTRY INTO THE PROFESSION

☐ Rule 64B11-2.012, F.A.C., requires an applicant seeking re-entry into the profession, **who has not been in active practice within the last five years**, to submit to the board documentation of 50 occupational therapy continuing education units, 12 of which may be home study, taken within the year prior to licensure.

Have you been in active practice with the last five years? ☐ Yes ☐ No ☐ NA- New Graduate

This requirement only applies to applicants who have held an OT or OTA license, had a break in active practice, and are now re-entering the profession.

Name: _____

12. REQUEST FOR TEMPORARY PERMIT – FOR EXAM APPLICANTS ONLY (OPTIONAL)

Temporary permits allow an applicant to work under the supervision of a licensed occupational therapist while waiting to take the examination and receive a successful score for full licensure. A temporary permit cannot be extended or renewed. If the applicant has **previously failed** the NBCOT examination, they are **ineligible** for a temporary permit. Additionally, the board may choose not to issue a temporary permit to any applicant they deem ineligible.

An individual who has been issued a temporary permit and receives notification of failing the examination must cease practicing occupational therapy under their temporary permit. The permit will be revoked by the board upon notification of the failing exam result. A temporary permit is revoked if the applicant fails to have the NBCOT send their successful scores to the board office within 12 months from the date of approval by the board.

If you are applying by examination and are requesting a temporary permit you must provide proof of a scheduled examination date for the NBCOT examination which contains a Confirmation of Appointment number, proof of requesting NBCOT scores transmittal to Florida and the name of your supervisor or employer. Contact NBCOT at (301) 990-7979 to apply for the examination prior to requesting a permit. A temporary permit will not be issued until official exam date confirmation is provided to the Florida board office and verified with the examination vendor. You may email confirmation to mqa.occupationaltherapy@flhealth.gov, fax to (850) 414-6860, or mail to the board office at:

Board *of* Occupational Therapy
4052 Bald Cypress Way Bin C-05
Tallahassee, FL 32399-3255

Are you requesting a temporary permit? ☐ Yes ☐ No

If "Yes," provide the following:

Supervisor Information
Name of Florida-licensed OT Supervisor:
License Number:
Employment Organization:
Employment Organization Address:
Email Address*:
Phone Number (Input without dashes):

*Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Temporary Permit Holder Information
Employment Organization:
Practice Address:

Name: _____

13. APPLICANT SIGNATURE

I, the undersigned, state that I am the person identified in this application for licensure in the state of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067 and 775.083, F.S.

Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

I hereby acknowledge that I have read the regulations in ch. 468, Part III, F.S., and chapter 64B11, F.A.C. I understand that I am under a continuing obligation to keep informed of any changes to ch. 468, F.S., and related rules. I further state that I will comply with all requirements for licensure renewal, including continuing education credits.

Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____
You may print this application and sign it or sign digitally. MM/DD/YYYY

*Applicants may **not** begin employment in Florida as an occupational therapist or occupational therapy assistant until they have received their Florida license.*

Complete verifications must be mailed directly from the licensing agency to:

Board *of* Occupational Therapy
4052 Bald Cypress Way Bin C-05
Tallahassee, FL 32399-3255

Board of Occupational Therapy License Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: _____

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

I hereby authorize release of any information regarding my licensure status to the Florida Board of Occupational Therapy.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

* Typed on an official state form or letterhead
* Include an official board seal
* Signature and title of state board official

The following information must be included in all verifications:

* Licensee name * License number * State or jurisdiction of licensure
* Licensure status * Is license in good standing?
* Date of issuance and expiration
* Licensure method (examination, grandfathering, reciprocity/endorsement) If exam, provide exam name, exam level, exam date, and score achieved.
* Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
* If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.