



[833-420-Revenue Code 0210 License Application Fee \$25]

[Payment made on \_\_\_\_\_ by check No \_\_\_\_\_]

**LIMITED PERMIT LICENSE APPLICATION**  
**OCCUPATIONAL THERAPY \_\_\_ or OCCUPATIONAL THERAPY ASSISTANT \_\_\_**

**Your Limited Permit is valid for 90 days from the NBCOT Date of Eligibility to Test letter.**

- ❖ Return signed, complete form with \$25 check or money order payable to the "OT Licensing Board".
- ❖ Have school transcripts sent directly to the Oregon OT Licensing Board.
- ❖ Send copy of your Authorization to Test letter from NBCOT (E-mail copy, letter or faxed).
- ❖ Have exam results from NBCOT sent directly to the Oregon Board.
- ❖ Have signed Statement of Supervision filed in the OTLB office prior to working under the LP

**LP License Expires 90 days from date of Eligibility Letter**

**PERSONAL INFORMATION**

1. FIRST NAME MI LAST NAME Other names used: \_\_\_\_\_

2. PREFERRED MAIL ADDRESS **Note:** Correspondence will be mailed to preferred address. SOCIAL SECURITY NO. BIRTH DATE  
 HOME (See Privacy Notification below)  
 WORK

3. HOME ADDRESS (MAILING: STREET OR PO BOX) HM. PHONE \_\_\_\_\_

4. CITY Home STATE HM. ZIP \_\_\_\_\_

5. E-MAIL ADDRESS (We save costs by use of e-mail; we do not give it out unless required by law; please keep it updated) \_\_\_\_\_

**EDUCATION**

COLLEGE / UNIVERSITY WHERE OT DEGREE RECEIVED CITY / STATE \_\_\_\_\_

DEGREE AREA OF STUDY GRADUATION DATE \_\_\_\_\_

**LICENSURE & HISTORY INFORMATION**

→ Have you signed up to take the National Certification Exam? Indicate date: \_\_\_\_\_ Yes  No

→ Have you received and included your Eligibility to Test letter from NBCOT? Yes  No

→ If not, when do you plan to take exam: \_\_\_\_\_  
 (Send NBCOT verification to the Oregon Board; or send NBCOT exam results)

I certify that everything in this application form is true and correct, cognizant that any falsification could result in denial, suspension, and/or revocation of my permit/license. I am aware that a license must be issued and approved prior to practicing Occupational Therapy in Oregon.

**X** \_\_\_\_\_ Date \_\_\_\_\_

**Applicant Signature**

**Return Application, fee & documents to:** OT Licensing Board, 800 NE Oregon St, Suite 407  
Portland, Oregon 97232

**BE SURE TO FILL OUT REGULAR APPLICATION FORM WHICH FOLLOWS AND ENCLOSE IT WITH THIS LP FORM**



[833-420-Revenue Code 0201 OT License Fee \$185 if issued before March, 2009; and for OT License \$100 if after March, 2009 ]  
RC 0206 OT Assistant Fee: \$ 130 if before March, 2009; for OT Assistant \$ 70 if after March, 2009 [Payment made on \_\_\_\_\_ by check No \_\_\_\_\_]

## OCCUPATIONAL THERAPY LICENSE APPLICATION

- ❖ Return signed, complete form. (If you are unsure of the fee, you will receive a letter with your LP regarding the fee).
- ❖ Send fee payable to the "OT Licensing Board" after you pass exam.)
- ❖ Have school transcripts for all newly licensed applicants sent to the Oregon Board.
- ❖ Have verification of your exam results from NBCOT sent to Oregon.

**License Expires May 31, 2010**

### PERSONAL INFORMATION

1.	FIRST NAME	MI	LAST NAME	
2.	PREFERRED MAIL ADDRESS <input type="checkbox"/> HOME <input type="checkbox"/> WORK	Note: Correspondence will be mailed to preferred address.	SOCIAL SECURITY NO. (See Privacy Notification below)	BIRTH DATE
3.	HOME ADDRESS (MAILING: STREET OR PO BOX)			HM. PHONE
4.	CITY	Home STATE	HM. ZIP	
5.	E-MAIL ADDRESS (We save costs by use of e-mail; we do not give it out unless required by law; please keep it updated)			

### EMPLOYMENT INFORMATION

6.	FACILITY	POSITION	
7.	WK. ADDRESS (MAILING: STREET OR PO BOX)	WK. PHONE	
8.	WK. CITY	WK. STATE	WK. ZIP

### EDUCATION

9.	COLLEGE / UNIVERSITY WHERE OT DEGREE RECEIVED	CITY / STATE	
10.	DEGREE	AREA OF STUDY	GRADUATION DATE

#### PRIVACY ACT NOTIFICATION: Use of Social Security Number

Oregon law authorized the State Occupational Therapy Licensing Board to request that you voluntarily allow the Board to use your Social Security Number for identification purposes in maintaining records, obtaining grades and exam scores, child support enforcement, tax administration and collection purposes, verification of licensure for employment, and verifying disciplinary or criminal background. Failure to allow your Social Security Number to be used for any of these purposes will not be used as a basis to deny you any right, benefit, or privilege provided by law. Your Social Security Number will be kept confidential by the board and used only for the purposes described above.

Please answer each question by putting a check  in the appropriate box. You must answer each question with either a "Yes" or "No" response. If you answer Yes, please provide a detailed explanation on a separate sheet of paper of the circumstances, include relevant dates, jurisdiction and/or parties involved, and sign and date the page.

14. Have you ever been cited, arrested, charged with or convicted of a crime, offence or violation of law in any state or by the Federal Government even if those charges were dismissed? Yes  No
15. Have you ever been the subject of a complaint or lawsuit regarding your Occupational Therapy or any other professional practice? Yes  No
16. Are there any unresolved or pending actions or complaints against you with any professional licensing or certifying authority? Yes  No
17. Have you ever voluntarily surrendered any license or certification? Yes  No
18. Have you ever been sanctioned by a professional licensing or certifying authority? Yes  No
19. Have you ever had limitations or restrictions placed on a professional license or certification? Yes  No
20. Do you have any condition that in any way impairs or may impair your capacity to perform duties of an Occupational Therapist with reasonable skill and safety? Yes  No

### SPECIALTY AREAS

Please check your area(s) of practice.

- |                                                   |                                         |                                              |                                              |
|---------------------------------------------------|-----------------------------------------|----------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Education      | <input type="checkbox"/> Geriatric           | <input type="checkbox"/> Hand                |
| <input type="checkbox"/> Home Health              | <input type="checkbox"/> Mental Health  | <input type="checkbox"/> Pediatric           | <input type="checkbox"/> Physical Disability |
| <input type="checkbox"/> Private Practice         | <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Sensory Integration | <input type="checkbox"/> Other _____         |

### SB 786 QUESTIONNAIRE

I do not wish to provide the following information.

- |                                                 |                                           |                                                         |
|-------------------------------------------------|-------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Caucasian              | <input type="checkbox"/> African American | <input type="checkbox"/> American Indian/Alaskan Native |
| <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Hispanic         |                                                         |

OTHER: \_\_\_\_\_

#### LANGUAGES (Other Than English)

- Bilingual?  Yes  No
- Spoken?  Yes  No
- Written?  Yes  No
- Fluent?  Yes  No

#### SELECT ALL THAT APPLY

- |                                  |                                                 |                                  |
|----------------------------------|-------------------------------------------------|----------------------------------|
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Vietnamese             | <input type="checkbox"/> Laotian |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Japanese               | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Korean  | <input type="checkbox"/> American Sign Language | <input type="checkbox"/> French  |
| <input type="checkbox"/> Tai     |                                                 | <input type="checkbox"/> German  |

### SIGNATURE OF APPLICANT

I agree to obey the laws, rules and regulations of the Oregon Occupational Therapy Licensing Board and to maintain the honor and dignity of the profession. I understand and agree that my license may be suspended or revoked by the Board at any time if I have made any false statements in this application or provided any false information, which resulted in the approval of my license application. I hereby certify that I am able to competently and safely perform the essential functions and duties of an Occupational Therapist.

I hereby declare that the information in this application, including any and all attachments, is true to the best of my knowledge and belief, and that I understand it is subject to penalty for perjury.

X

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

\_\_\_\_\_  
Date



**TO THE SUPERVISOR**  
**OF THE LIMITED PERMIT HOLDER**

For OT \_\_\_\_\_ For OTAssistant \_\_\_\_\_

1. Please complete this section by printing legibly. Please provide the full name of the employing agency.
2. The supervisor certifies that the permittee will be employed and work under the supervision of an Oregon-licensed occupational therapist and that the expiration date of the limited permit will be noted and observed.
3. The limited permit is valid only until the Board receives results of the certification the exams. **Should the Limited Permit Holder Fail the Certification Exam, the Limited Permit Immediately Is Void and Must Be Surrendered upon Receipt Of Exam Scores. The Limited Permit Cannot Be Renewed.**
4. Limited permit holders require at least **routine supervision** (direct contact at least every two weeks at the work site with interim supervision occurring by other methods, such as telephone or written communication).

***I certify that I will provide supervision as defined in OAR 339-010-0005(1)(b) for the limited permit holder named:***

OAR 339-010-0005(1) states that "Supervision" is a process in which two or more people participate in a joint effort to promote, establish, maintain and/or evaluate a level of performance. The occupational therapist is responsible for the program outcomes and documentation to accomplish the goals and objectives.

☛ **(Supervising OT Signature no longer needs to be Notarized)** ☚

Applicant Information o	Supervisor Information o
Print Name of Applicant	Print Name of Supervising OT
Date Supervision To Begin	Signature & License No. Of Supervising OT (must be notarized*)
Employer's Name	Telephone
Employer's Address	

After this Statement of Supervision form has been completed, please mail it either with your Limited Permit Application, or separately, to:

<p><b>Occupational Therapy Licensing Board</b> * Suite 407, 800 NE Oregon, * Portland, OR 97232</p> <p>Telephone: (971) 673-0198 * Fax: (971) 673-0226</p> <p><b><a href="http://www.otlb.state.or.us">www.otlb.state.or.us</a></b></p>
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