# Maryland Board of Occupational Therapy Practice

**Spring Grove Hospital • 55 Wade Avenue • Bland Bryant Building, 4th Floor • Baltimore, MD 21228**
**Phone: 410-402-8560 • Fax: 410-402-8561 • www.dhmh.maryland.gov/botp**

## Application for License Renewal

**RENEWAL DEADLINE: 5/31/2015 (POSTMARKED)**

**GRACE PERIOD: 6/1 – 6/30/2015 (POSTMARKED)**

SOCIAL SECURITY NUMBER: _____-_____-_____

**I attest to earning the required continuing education credits indicated below: (check either 1 or 2)**

☐ 1. Is your certification current with NBCOT? or
☐ 2. Did you complete 12 contact hours of continuing education?
☐ 3. If you answered yes to question #2, check here if any hours were carried over from the previous cycle?

Home Phone: (_____) _____
Work Phone: (_____) _____
Email address: _____

| **Fees (Make checks payable to: MD Board of OT)** | **Total Due** | **Amount Enclosed** |
|---|---|---|
| OT – Occupational Therapist – includes $127 Renewal Fee + $18 MHCC Fee | $145 | _____ |
| OTA – Occupational Therapy Assistant | $100 | _____ |
| Elective Non-Renewal Status (Inactive) | $25 | _____ |
| Renewal Late Fee - $25 for renewal applications postmarked between 6/1 and 6/30 | $25 | _____ |

**Write YES or N/A (not applicable) for the following, since your last renewal:**

____ 4. During the last year, have you been addicted to drugs or alcohol?
____ 5. During the last year, has any state licensing or disciplinary board, or a comparable body in the armed services, denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, or revocation?
____ (b) During the last year, have you surrendered a license in any jurisdiction due to disciplinary proceedings?
____ 6. During the last year, are there any outstanding complaints, investigations or charges pending against you in any jurisdiction (including Maryland) by any licensing or disciplinary board or a comparable body in the armed services?
____ 7. During the last year, have you had a physical, or mental illness that currently impairs your ability to practice your profession?
____ 8. During the last year, have you pled guilty, nolo contendre, or been convicted of, or received probation before judgment for any criminal act?
____ 9. During the last year, have you pled guilty, nolo contendre, or been convicted of, or received probation before judgment of driving while intoxicated or of a controlled dangerous substance offense?
____ 10. During the last year, has any hospital or related healthcare institution or employer denied you privileges or employment, denied any application or contract or limited, restricted, suspended, revoked, or terminated your privileges or employment contract for any reason related to your practice?
____ 11. During the last year, have the conditions of your employment been affected by any termination of employment, suspension, or probation for any reason related to your practice?
____ 12. During the last year, has a malpractice suit been filed against you or has a claim for damages been settled or awarded against you?
____ 13. During the last year, have you knowingly practiced occupational therapy in the State of Maryland or any other jurisdiction without an active license?

**If YES is answered to any question, attach a detailed explanation for each question answered yes and include a certified copy of court records, if applicable.**

**Health Occupations Article** §1-202 requires that you verify that you are complying with the Worker's Compensation Law for your renewal to be issued. **Please check one**. I hereby certify:

(a) ☐ I practice in Maryland, and employ one or more persons in my practice and will maintain Workmen's Compensation coverage continuously throughout the license renewal period. **If YES to (a), complete insurance information below.**

Insurance Company: _____ Policy Number: _____ Expiration Date: _____ **OR**

(b) ☐ I practice in Maryland, but I do not employ anyone in my practice, **OR** (c) ☐ I do not practice in Maryland.

**Notice for Mailing List**

The information collected on the license application form and the license renewal forms is collected for the purposes of the Board's functions under the Maryland Health Occupations Code Annotated, Title 10. Failure to provide the information may result in the denial of your application for an initial or renewed license. You have a right to inspect, amend, and correct this information. The Board may permit inspection of this information, or make it available to others, only as permitted by federal and State law. The Board may sell or provide a list of licensees' names and addresses to professional associations and other entities. Under the Maryland Public Information Act, Maryland State Government Code Annotated 10-617, you may request in writing that your name be omitted from such lists.

Area of Practice/Specialty: Please check one:

1. ☐ Mental Health
2. ☐ Productive Aging
3. ☐ Children and Youth
4. ☐ Work and Industry
5. ☐ Rehab, Disability & Participation
6. ☐ Other
7. ☐ None

Race/Ethnicity: Voluntarily please check all that apply:

1. ☐ American Indian or Alaska Native
2. ☐ Asian
3. ☐ Black or African American
4. ☐ Hispanic or Latino
5. ☐ Native Hawaiian or other Pacific Islander
6. ☐ White

**Complete If Name Changed. Include Copy Of Legal Document.**

Last Name & Generational Indicator (Jr., III, Etc.):

_____

First Name & Middle Name/Initial:

_____

**Complete If Address Changed.**

Address: _____

_____

City: _____ State: _____

Zip Code: _____

Practice of occupational therapy without an active license is a violation of the Occupational Therapy Practice Act.

I affirm that the content of this document is true and correct to the best of my knowledge and belief.

Signature: _____

Date: _____

License Number: _____