

MARYLAND BOARD OF OCCUPATIONAL THERAPY
 SPRING GROVE HOSPITAL • BLAND BRYANT BUILDING, 4TH FLOOR
 55 WADE AVENUE • BALTIMORE, MARYLAND 21228
 Phone 410-402-8560 • Fax 410-402-8561 • www.dhmh.maryland.gov/botp

CHANGE OF INFORMATION REQUEST

The law requires that Occupational Therapists and Occupational Therapy Assistants notify the Board in writing within 30 days of any change of address and/or name change. This is very important since the Board is required only to attempt to contact you at the address we have on record.

The Board is authorized to proceed with its duties, including discipline, after it has attempted to contact you at the address of record, with or without your participation. Failure to notify the Board of an address/name change may result in your failure to receive a renewal application, which may in turn lead to disciplinary action for practicing on an expired license.

The Board must, by law, have a valid address/name for you. The address/name that you provide is the "address/name of record" that is available for public information requests. Please provide a full mailing address and phone number at which you can be reached during the day.

Untimely notification to the Board of an address/name change will result in a late fee of \$50.

Name:		License Number:	
Notice for Mailing Lists			
The information collected is for the purposes of the Board's functions under Annotated Code of Maryland 10.46.01.02. 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, MD State Government Code Ann. §10-617, you may request in writing that your name be omitted from such lists.			
PLEASE DARKEN THE APPROPRIATE BOX			
What information has changed?			
<input type="checkbox"/> Name	<input type="checkbox"/> Home Address	<input type="checkbox"/> E-mail Address	<input type="checkbox"/> Home Phone
<input type="checkbox"/> Work Phone			
NAME CHANGE			
Previous Name:		New Name:	
<i>If you are requesting a change of name, please submit a copy of a legal name change document, marriage certificate, or divorce decree.</i>			
ADDRESS CHANGE			
Old Mailing Address		New Mailing Address	
Street:		Street:	
City:		City:	
State:	Zip:	State:	Zip:
PHONE NUMBER CHANGE			
Home Number		Work Number	
Old:		Old:	
New:		New:	
E-MAIL ADDRESS CHANGE			
New E-mail Address:			
I affirm that the contents of this document are true and correct to the best of my knowledge and belief. Further, I authorize the Board to update their records to reflect this information.			
Signature: _____		Date: _____	
For Office Use:			
Date Received:		Date Processed:	