



MD BOARD OF OCCUPATIONAL THERAPY PRACTICE

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

MORAL CHARACTER ENDORSEMENT FORM

The Maryland State Board of Occupational Therapy Practice is gathering information to determine whether the applicant for licensure to practice occupational therapy in Maryland can be anticipated to do so ethically. **Persons who complete this form must have observed the applicant's clinical skills, and not be related to the applicant.**

Name of Applicant: _____ Social Security Number: _____ - _____ - _____

Address: _____

City/State/Zip: _____ Phone (____) _____

- License Type You Are Applying For:
- Occupational Therapist
 - Occupational Therapy Assistant
 - Temporary Occupational Therapist
 - Temporary Occupational Therapy Assistant

To the best of your knowledge, has the applicant:

- | | |
|---|---|
| 1. Provided appropriate services to clients without discrimination based on age, race, creed, national origin, sex, sexual orientation, handicap, or religious affiliation? | 1. <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. Shown respect for clients' rights, including the right to refuse treatment? | 2. <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. Avoided cruel, inhumane, or degrading practices in the treatment of clients? | 3. <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 4. Provided the highest quality services to clients? | 4. <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 5. Placed the needs of the client above personal gains, financial or otherwise? | 5. <input type="checkbox"/> YES <input type="checkbox"/> NO |

CONTINUED ON BACK

TDD FOR DISABLED
 MARYLAND RELAY SERVICE
 1-800-735-2258

- | | |
|---|--|
| 6. Appropriately represented his or her skills? | 6. <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 7. Continued with any procedure which appeared to be harmful to the client? | 7. <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 8. Practiced occupational therapy without an appropriate license? | 8. <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 9. Used any form of communication containing a false, fraudulent, misleading, or deceptive claim? | 9. <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 10. Failed to comply with any laws dealing with the practice of occupational therapy? | 10. <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 11. How long have you been acquainted with the applicant? | 11. _____ Years
_____ Months |

12. Describe the manner in which you are familiar with the applicant's clinical skills.

13. I attest that the information provided is true to the best of my knowledge:

_____ Name	_____ Signature
_____ Job Title	_____ Date
_____ Address	_____ City/State/Zip
(_____) _____ Home Phone number	(_____) _____ Work Phone Number

If this form has been completed by someone who has not observed the applicant's clinical skills, it will be rejected and may delay the processing of this application.

DO NOT FORWARD THE COMPLETED FORM TO THE APPLICANT.
The completed **original** form must be returned directly to:

MD Board of Occupational Therapy
Spring Grove Hospital Center
Bland Bryant Building, 4th Floor
55 Wade Avenue
Baltimore, MD 21228

FAXED COPIES WILL NOT BE ACCEPTED.