

MARYLAND BOARD OF OCCUPATIONAL THERAPY PRACTICE
Spring Grove Hospital Center ♦ Bland Bryant Building, 4th Floor
55 Wade Avenue ♦ Baltimore, MD 21228
Phone: 410-402-8560 ♦ Fax: 410-402-8561
www.dhmf.maryland.gov/botp

VERIFICATION OF LICENSURE FORM

PART I: TO BE COMPLETED BY APPLICANT

1. Name: _____ 2. Social Security Number: ____ - ____ - ____
3. Address: _____
4. City: _____ 5. State: _____ 6. Zip: _____
7. Home Phone: (____) _____ 8. Work Phone: (____) _____
9. Type of License Applying for: Occupational Therapist Occupational Therapy Assistant
 Temporary Occupational Therapist Temporary Occupational Therapy Assistant
10. State or foreign country in which you are/were licensed: _____ None
Make a copy of this form for each state or foreign country in which you are or ever have been licensed.

PART II: TO BE COMPLETED OR RETURNED WITH EQUIVALENT DOCUMENTATION BY STATE OR FOREIGN COUNTRY.

The Occupational Therapist or Occupational Therapy Assistant listed above has applied for licensure in the State of Maryland. Please provide the following information.

11. Occupational Therapist Yes No 12. Occupational Therapy Assistant Yes No
13. License Number _____ 14. Status: _____
15. Date Issued: _____ 16. Expiration Date: _____
17. Did the licensee obtain a temporary license only? Yes No
18. If yes, can the temporary license be verified via this form? Yes No
19. Are you or have you ever had any disciplinary action taken against your license in any state or country? Yes No
20. If yes, please give particulars on the reverse side of this form and include a copy of any Order.
21. The Board of _____ of the State of _____ certifies that the above information is correct.
22. Signature _____
Title _____
Date _____
Agency Address _____

PLEASE RETURN DIRECTLY TO THE MARYLAND BOARD OF OT

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