GEORGIA STATE BOARD OF OCCUPATIONAL THERAPY

237 Coliseum Drive * Macon, Georgia 31217-3858 * (478) 207-2440
http://sos.ga.gov/index.php/licensing/plb/36

APPLICATION FOR LICENSE REINSTATEMENT

GENERAL INSTRUCTIONS

Please Read These Instructions and the Law And Rules Carefully Prior To Completing Application. Submit ALL required documents with the application forms. Incomplete applications will cause delays in processing.

ALL APPLICANT'S MUST SUBMIT THE FOLLOWING DOCUMENTS:	
APPLICATION FEE	Please refer to fee schedule for appropriate remittance. The respective fee must accompany each application. The application fee is non-refundable and cannot be combined with any other fee. Checks returned for insufficient funds will be assessed a service charge pursuant to O.C.G.A. §16-9-20.
APPLICATION	Type or print in ink. You must respond to all the questions and requests on the application or it will be returned for you to complete.
CONTINUING EDUCATION	Applicants for reinstatement are subject to automatic continuing education audit. You must submit documentation of 24 hours of continuing education with 2 hours of Ethics. Many applications are delayed because of incomplete documentation of continuing education; please refer to Rule 671-3-.09 for complete instructions. The continuing education must be completed within two (2) years of the date of this application. Please complete the CE reporting form, page 13.
VERIFICATION OF CURRENT LICENSE	Applicants for reinstatement who hold, or have held, a license in another state will be required to request license verification with the state's seal. mailed directly from that state to the Georgia Board, or included with your application documents.
VERIFICATION OF EMPLOYMENT	Applicants must submit employment verification to most recent employer to verify last date of practice in Occupational Therapy. The signed, notarized form must be submitted by the applicant with the application.
REFERENCES	Three (3) references are required. The references must have known you within the past five (5) years and must not be related to you. The three (3) completed, signed and notarized reference forms must be submitted by the applicant with the application. Two (2) references must be from certified or licensed occupational therapy practitioners, or any other healthcare professional, who have knowledge of the applicant's professional training or experience during the last five years. The third reference is a personal reference. Applicants who have not practiced within the past five (5) years may submit Form B (Certification of completion of Supervised Clinical Experience) to satisfy the requirements of Rule 671-3-.09 (2a).
APPLICANTS WITH AN EXPIRED LICENSE WHO HAVE NOT PRACTICED WITHIN FIVE YEARS OF THE DATE OF THIS REINSTATEMENT APPLICATION MUST SUBMIT THE FOLLOWING:	
	Pursuant to Rule 671-3-.09, Verification of completion of 320 hours of supervised clinical experience (under the supervision of a licensed occupational therapist). A description of the training must be submitted using Form A (page 11) for Board approval, and take place in a facility, which meets the requirements of an accredited or approved occupational therapy or occupational therapy assistant curriculum. The applicant must submit "Form A" (see page 11) for Board approval with the application. Upon approval of submitted Form A, a 90 day limited permit will be issued.

BOARD REVIEW: All applications for reinstatement must be presented to the Board for review. It is important to submit a completed application with all supporting documents and verifications to avoid delays in the processing of the application and presentation to the Board. Decisions of the board are disseminated within 10 business days following the board meeting. The board staff is not authorized to discuss board decisions over the telephone with the applicant or any third party. Visit https://secure.sos.state.ga.us/PLB_appStatus/ to check the status of your application.

ADDRESS, E-MAIL AND NAME CHANGES: Please notify this office immediately, in writing, of any addresses and/or name changes. All name changes must include a copy of the official document that changes the name. (Social security cards and drivers licenses are not acceptable). You may also change your address on the Board's website.

FOR BOARD USE ONLY
Amount Submitted _____
Date _____
Receipt # _____

FOR BOARD USE ONLY
Certificate Number _____
Date Issued _____
Applicant No. _____

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APPLICATION FOR LICENSE REINSTATEMENT

OCCUPATIONAL THERAPIST *or* OCCUPATIONAL THERAPY ASSISTANT

Application Fee: **OT** - $100.00 **(non-refundable) *** Application Fee: **OTA** - $80.00 **(non-refundable)**
Checks returned for insufficient funds will be assessed a service charge pursuant to O.C.G.A. § 16-9-20

NAME: _____
Last First Middle Maiden

NAME in which license was originally issued

(If different): _____
Last First Middle Maiden

ADDRESS: _____
Home/Physical Address: Street (P.O. Box, not acceptable) Apt. No. City/State Zip Code

MAILING ADDRESS IF DIFFERENT THAN HOME ADDRESS: _____
Street/P.O. Box Apt. No. City/State Zip Code

If you are granted a license, your name, mailing address and license number are public information. Your physical address is required, if different that the mailing address. You must immediately notify the Board in writing of an address change.

_____ _____ **DATE OF BIRTH:** _____/_____/_____
TELEPHONE NUMBER (DAY) TELEPHONE NUMBER (NIGHTS)

SOCIAL SECURITY NUMBER: _____/_____/_____
(THIS INFORMATION IS AUTHORIZED TO BE OBTAINED AND DISCLOSED TO STATE AND FEDERAL AGENCIES PURSUANT TO O.C.G.A. §§19-11-1 & 20-3-295, 42 U.S.C.A §§551, 20 & 101)

E-MAIL ADDRESS: _____
Acknowledgement of your application will be sent by e-mail. Also, if any additional information is needed, e-mail is the most efficient way for the Board staff to contact you so that your application can be processed in the most efficient manner. Please notify the Board of any e-mail address change. YOUR E-MAIL ADDRESS WILL NOT BE SHARED WITH ANY THIRD PARTY.

APPLICATION FOR REINSTATEMENT OF A LICENSE

Instructions:
1. Please read these instructions thoroughly before completing this application.
2. Fully complete this application. Type or print clearly. Sign and have the application notarized.
3. Enclose the non-refundable application fee. Checks returned for insufficient funds will be assessed a service charge pursuant to O.C.G.A. §16-9-20.
4. Please complete the CE reporting form and include Certificates of Completion/Attendance and Course Brochure/Outline for 24 hours of continuing education obtained within two (2) years of the date of this application.
5. Please request your employer complete the employment verification form verifying last date(s) of practice and clarifying your job duties and submit the form with your application.
6. Please submit (2) Professional References from a licensed OT or any other licensed healthcare professional, and (1) Personal reference with your application.
7. If you hold, or have ever held, a license from another state, please contact that state to request license verification be mailed directly to Georgia Board with the state's seal on it. The Board does not consider a copy of your duplicate pocket card as verification of license.

✓ CHECK TYPE OF APPLICATION

☐ OCCUPATIONAL THERAPIST - $100.00 ☐ OCCUPATIONAL THERAPY ASSISTANT - $80.00

11. GA Lic # _____ Date Issued: _____ Date Expired: _____

12. Previously granted Physical Agent Modalities certification in GA? Yes_____ No _____

13. List any state where you hold, or have held, a current/temporary license or permit: State_____ License# _____
Current? ___ Yes ____No
State_____ License# _____
Current? ___ Yes ____No
State_____ License# _____
Current? ___ Yes ____No

**Note: Please attach additional states on separate paper, and contact each state for license verification.

14. Reason for not renewing: _____

_____

_____

_____

15. EMPLOYMENT HISTORY (INDICATE MOST RECENT FIRST)

A. EMPLOYER: _____ Dates: _____

Address: _____ City/State _____

Job Title & Responsibilities: _____

_____

_____

_____

B. EMPLOYER: _____ Dates: _____

Address: _____ City/State _____

Job Title & Responsibilities: _____

_____

_____

_____

(Add additional sheets if needed)

16. IF YOU HAVE NOT PRACTICED OCCUPATIONAL THERAPY WITHIN THE LAST 5 YEARS, PLEASE INDICATE THE FOLLOWING:

a. I will complete 320 hours of supervised clinical experience with the following Occupational Therapist:

_____	_____	_____	_____
Name of Occupational Therapist	**License Number/State**	**Issue Date**	**Expiration Date**

b. I will complete the training at the following facility: _____

_____

IMPORTANT:
If you are reinstating a license that has been lapsed for five (5) or more years, in addition to the CE Hours, you must complete Form A and submit to Board for review.
Then, upon completion of the supervised training you must submit Form B to the Board documenting completion.

671-3-.09 Reinstatement of a License. Amended.
(1) Reinstatement of an expired license is within the discretion of the Board.
(2) A license may be reinstated by submission of the following:
(a) Application for Reinstatement with appropriate fee, including references as required under Rule 671-3-.02; and
(b) Documentation of the completion of twenty-four (24) continuing education hours in accordance with Board rule **671-3-.08 Renewal of License/Penalties/Continuing Education Requirements** obtained within the two (2) year period prior to the date of the application.
(c) Verification of current license in another state, if applicable; and
(d) Verification of Employment verifying last date of practice in Occupational Therapy, on the Board form, completed by the employer.
(3) An applicant for reinstatement of a license who has **not** practiced within five (5) years must also submit the following:
(a) Form A (Supervised Clinical Experience) indicating who will provide 320 hours of supervised clinical experience with a description of the training for Board approval. Upon approval by the Board a limited permit will be issued.
(b) Upon completion of the supervised clinical experience, an applicant must submit Form B (Certification of Completion of Supervised Clinical Experience) verifying the 320 hours of clinical experience under the supervision of a licensed occupational therapist, pursuant to Rule 671-3-.06, for Board approval

BACKGROUND INFORMATION

17. HAS ANY OTHER LICENSING BOARD OR AGENCY IN GEORGIA OR ANY OTHER STATE EVER:

A. ☐YES ☐NO DENIED YOUR LICENSE APPLICATION, RENEWAL, OR REINSTATEMENT?

B. ☐YES ☐NO REVOKED, SUSPENDED, RESTRICTED, OR PROBATED YOUR LICENSE?

C. ☐YES ☐NO REPRIMANDED, FINED, DISCIPLINED, REQUESTED OR ACCEPTED SURRENDER OF YOUR LICENSE? If you answered "yes" to any of the above, you must submit a letter of explanation and request that the licensing board, NBCOT or agency send a certified copy of the action taken against your license or certification with relevant supporting documents to the Georgia Board of Occupational Therapy 237 Coliseum Drive, Macon, GA 31217. Your application must be reviewed by the Board and will not be considered complete until the information is received.

18. ☐YES ☐NO HAVE YOU EVER BEEN ARRESTED, CONVICTED, SENTENCED, PLED GUILTY, OR NOLO CONTENDERE OR BEEN GIVEN FIRST OFFENDER STATUS FOR ANY FELONY, MISDEMEANOR OR ANY OFFENSE OTHER THAN A MINOR TRAFFIC VIOLATION? (DWI AND DUI ARE NOT MINOR TRAFFIC VIOLATIONS.) If yes, please provide a complete explanation of each offense and provide certified copies of the final court disposition. (Note: You must respond, "yes" if you pleaded and completed probation as a First Offender.)

19. ☐YES ☐NO HAVE YOU FAILED TO RENEW A LICENSE, CERTIFICATION OR REGISTRATION DURING AN INVESTIGATION AGAINST YOU BY A LICENSING BOARD OR OTHER AGENCY?

20. ☐YES ☐NO IS THERE ANY DISCIPLINARY ACTION OR INVESTIGATION PENDING AGAINST YOU BY ANY LICENSING BOARD, AGENCY, OR NATIONAL CERTIFYING ORGANIZATION?

21. ☐YES ☐NO HAVE YOU EVER HAD ANY PROFESSIONAL LIABILITY SUITS FILED AGAINST YOU?

22. ☐YES ☐NO HAVE YOU USED DRUGS OR OTHER INTOXICATING SUBSTANCES TO THE EXTENT THAT THESE AFFECTED YOUR PROFESSIONAL COMPETENCE?

If you answered yes to any of the above questions, you must attach a letter of explanation. You are expected to read each question carefully and completely and to provide updated information for any changes. You will be asked to certify under oath that the answers are true and correct. Failure to answer these questions truthfully and correctly may be grounds for denial of your application or other disciplinary action against you. The Board must review the letter of explanation and any supporting documents and your application will not be considered complete until the information is received.

APPLICANT SIGNATURE & AFFIDAVIT

YOU MUST SIGN THIS AFFIDAVIT IN THE PRESENCE OF A NOTARY

I hereby swear and affirm that all information provided in this application is true and correct to the best of my knowledge and belief. I further swear and affirm that I have read and understand the current state laws and rules and regulations of the Georgia State Board of Occupational Therapy, and I agree to abide by these laws and rules, as amended from time to time.

By signing this application, electronically or otherwise, I hereby swear and affirm one of the following to be true and accurate pursuant to O.C.G.A. § 50-36-1:

1) _____ I am a United States citizen 18 years of age or older. **Please submit a copy of your current Secure and Verifiable Document(s) such as driver's license, passport, or other document as indicated on pages 6 & 7 of this application.**

2) _____ I am **not** a United States citizen, but I am a legal permanent resident of the United States 18 years of age or older, or I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act 18 years of age or older with an alien number issued by Department of Homeland Security or other federal immigration agency. **Please submit a copy of your current immigration document(s) which includes either your Alien number or your I-94 number and, if needed, SEVIS number (See pages 6 & 7 of this application).**

In making the above attestation, I understand that any failure to make full and accurate disclosures may result in disciplinary action by the Georgia State Board of Occupational Therapy and/or criminal prosecution.

_____ _____

Signature of Applicant Date

Sworn to and subscribed before me this

_____ day of _____ 20_____

_____ (Notary Seal)

Notary Public Signature

My Commission Expires: _____

NOTE to NOTARY: Application must be signed with Proper ID.

APPLICANT: PLEASE CHECK THE FORM OF IDENTIFICATION BELOW THAT YOU POSSESS. RETURN THIS FORM ALONG WITH A COPY OF YOUR APPROPRIATE DOCUMENTATION.

_____
(Printed Name of Applicant)

Secure and Verifiable Documents Under O.C.G.A. § 50-36-2 Issued
July 10, 2013 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 ("IIREA"), as amended by Senate Bill 160, signed into law as Act No. 27, (2013), provides that "[n]ot later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law's website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General." O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

_____An unexpired United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____An unexpired United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____An unexpired driver's license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____An unexpired identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A unexpired tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at:
http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____An unexpired United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____An unexpired Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A unexpired passport issued by a foreign government, provided that such passport is accompanied by a United States Department of Homeland Security (DHS") Form I-94, DHS Form I-94A, DHS Form I-94W, or other federal form specifying an individual's lawful immigration status or other proof of lawful presence under federal immigration law1 [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____An unexpired Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____An unexpired Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

_____An unexpired NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

_____An unexpired Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. §50-36-2(b)(3); 22 CFR § 41.2]

_____An unexpired driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

_____A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

_____Certification of Report of Birth issued by the United States Department of State (Form DS-1350) [O.C.G.A. § 50-36-2(b)(3); 6 CFR 37.11]

_____Certification of Birth Abroad issued by the United States Department of State (Form FS-545) [O.C.G.A. § 50-36-2(b)(3); 6 CFR 37.11]

_____Consular Report of Birth Abroad issued by the United States Department of State (Form FS-240) [O.C.G.A. § 50-36-2(b)(3); 6 CFR 37.11]

_____An original or certified copy of a birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal [O.C.G.A. § 50-36-2(b)(3); 6 CFR 37.11]

In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § 50-36-2(c)]

_____

Senate Bill 160 (Act No. 27), effective July 1, 2013, limited the use of passports issued by foreign nations to satisfy the requirements for submission of secure and verifiable documents to only those passports submitted in conjunction with a United States Department of Homeland Security ("DHS") Form I-94, DHS Form I-94A, DHS Form I-94W, or other federal form specifying an individual's lawful immigration status or other proof of lawful presence under federal immigration law.

GEORGIA STATE BOARD OF OCCUPATIONAL THERAPY
237 Coliseum Drive, Macon, Georgia 31217-3858

VERIFICATION OF EMPLOYMENT

Instructions:
1. Applicant: complete Section I and sign.
2. Submit this form to your most recent **employer (Personnel Director, Human Resources Department)** who can provide verification of your practice in Occupational Therapy. **Submit this completed, signed and notarized form with your application materials.**

Section I (To be completed by applicant)

Printed Name of Applicant: _____
Last **First** **Middle** **Maiden**

Applicants Address: _____
Street **City** **State** **Zip Code**

RELEASE: I do hereby consent to and authorize the release of any and all records and information concerning my employment as an Occupational Therapist and Occupational Therapy Assistant to the Georgia Board of Occupational Therapy. I understand this information is required as part of the application for licensure process

_____ _____
Signature of Applicant: Applicant Phone Number(s):

_____ _____

APPLICANT – DO NOT WRITE BELOW THIS LINE:

Section II (To be completed by person verifying employment)

Instructions:
1. Complete Section II of this form.
2. Occupational Therapy employment must have been for compensation.
3. Return the signed, notarized and completed form to applicant for submission with their application materials.

1. Name of Business: _____ Phone Number: _____

2. Physical Location of practice: _____
(City/State/Zip Code)

3. Applicant's Position/Title: _____ 4. Employment Dates: From: _____ To: _____

5. Description of Applicant's experience in facility: _____

_____

6. Printed name and title of person verifying employment: _____
(Name) (Title)

_____
(Signature of Individual Completing this information)

Sworn to and subscribed before me this

_____
Signature of Employer/Person completing this form

_____ **day of** _____**, 20**____

_____ **(Notary Seal)**
Notary Public Signature

My commission expires: _____

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(478) 207-2440 * http://sos.ga.gov/index.php/licensing/plb/36

REFERENCE – PROFESSIONAL

APPLICANT: Please have a certified, licensed or registered Occupational Therapist who has knowledge of the applicant's professional training or experience during the last five years to complete this form. Print your name and indicate the type of license you are seeking.

NAME: _____ **(hereinafter applicant), ☐OT ☐OTA**

Applicant: DO NOT WRITE BELOW THIS LINE

PROFESSIONAL REFERENCE: This form must be returned to the board with the completed application by the applicant. Please complete the following information, sign in the presence of a Notary and return to applicant for submission with the application. If you are an occupational therapist licensed, certified or registered in another country, please include, on a separate sheet, the name, address, and telephone number of the agency that regulates or oversees the practice of occupational therapy.

Your Name: _____ **Telephone Number:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

NBCOT Number: _____ **License Number:** _____ **State:** _____ **Current? YES ☐ NO☐**

How long have you known the applicant? _____

PLEASE COMPLETE *ONE* OF THE FOLLOWING STATEMENTS:

STATEMENT FOR OCCUPATIONAL THERAPIST APPLICANT:

Under penalty of perjury, I declare and attest that I have direct and actual knowledge of _____
(Print OT Applicant's Name)
(hereinafter, applicant) and that I have known and observed the applicant within the last 5 years and that based on my direct observations, I find the applicant to be honest, have integrity and be of good moral character and that I have observed the OT applicant, to be competent in the areas of planning, directing, implementing and supervising the evaluation of a client and planning and implementing appropriate occupational therapy programs and that the applicant has competency in Occupational Therapy.

STATEMENT FOR OCCUPATIONAL THERAPY ASSISTANT APPLICANT:

Under penalty of perjury, I declare and attest that I have direct and actual knowledge of _____
(Print OTA Applicant's Name)
(hereinafter, applicant) and that I have known and observed the applicant within the last 5 years and that based on my direct observations, I find the applicant, to be competent to assist in the evaluation of a client, in the evaluation and implementation of appropriate occupational therapy programs and to seek instruction/supervision from the supervisor when needed.

I AM UNABLE TO SUBMIT A REFERENCE FOR _____
(Print applicant's Name)

In the State of _____**, County of** _____
Sworn to and subscribed before me this _____ **day of** _____**, 20**____**.**

_____ **(SEAL)**
Signature of Notary

My commission expires: _____

_____
Reference Signature

_____
Date

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REFERENCE – PROFESSIONAL

APPLICANT: Please have a certified, licensed or registered Occupational Therapist who has knowledge of the applicant's professional training or experience during the last five years complete this form. Print your name and indicate the type of license you are seeking.

NAME: _____ **(hereinafter applicant), ☐OT ☐OTA**

Applicant: DO NOT WRITE BELOW THIS LINE

PROFESSIONAL REFERENCE: This form must be returned to the board with the completed application by the applicant. Please complete the following information, sign in the presence of a Notary and return to applicant for submission with the application. If you are an occupational therapist licensed, certified or registered in another country, please include, on a separate sheet, the name, address, and telephone number of the agency that regulates or oversees the practice of occupational therapy.

Your Name: _____ **Telephone Number:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

NBCOT Number: _____ **License Number:** _____ **State:** _____ **Current?** **YES** ☐ **NO**☐

How long have you known the applicant? _____

PLEASE COMPLETE *ONE* OF THE FOLLOWING STATEMENTS:

STATEMENT FOR OCCUPATIONAL THERAPIST APPLICANT:

Under penalty of perjury, I declare and attest that I have direct and actual knowledge of _____
(Print OT Applicant's Name)
(hereinafter, applicant) and that I have known and observed the applicant within the last 5 years and that based on my direct observations, I find the applicant to be honest, have integrity and be of good moral character and that I have observed the OT applicant, to be competent in the areas of planning, directing, implementing and supervising the evaluation of a client and planning and implementing appropriate occupational therapy programs and that the applicant has competency in Occupational Therapy.

STATEMENT FOR OCCUPATIONAL THERAPY ASSISTANT APPLICANT:

Under penalty of perjury, I declare and attest that I have direct and actual knowledge of _____
(Print OTA Applicant's Name)
(hereinafter, applicant) and that I have known and observed the applicant within the last 5 years and that based on my direct observations, I find the applicant, to be competent to assist in the evaluation of a client, in the evaluation and implementation of appropriate occupational therapy programs and to seek instruction/supervision from the supervisor when needed.

I AM UNABLE TO SUBMIT A REFERENCE FOR _____ **(Print Applicant's Name)**

In the State of _____**, County of** _____
Sworn to and subscribed before me this _____ **day of** _____**, 20**____**.**

_____ **(SEAL)**
Signature of Notary

My commission expires: _____

_____
Reference Signature

_____
Date

_____

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REFERENCE – PERSONAL

APPLICANT: Please have a NON-RELATED INDIVIDUAL COMPLETE THIS FORM. Individual completing this form does not have to be a licensed/certified Occupational Therapist. Print your name and indicate the type of license you are seeking.

NAME: _____ **(hereinafter applicant), ☐OT ☐OTA**

Applicant: Do Not Write Below This Line

PERSONAL REFERENCE: This form must be returned to the board with the completed application by the applicant. Please complete the following information, sign in the presence of a Notary and return to applicant for submission with the application:

Your Name: _____ **Telephone Number:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

REFERENCE: PLEASE COMPLETE *ONE* OF THE FOLLOWING STATEMENTS:

STATEMENT FOR LICENSURE:

Under penalty of perjury, I declare and attest that I have direct and actual knowledge of _____
Print Applicant's Name
(hereinafter, applicant) and that I have known and observed the applicant within the last 5 years and that I am not related to the applicant. I believe the applicant to be honest, have integrity and be of good moral character.

I AM UNABLE TO SUBMIT A REFERENCE FOR _____**(Print applicant's Name)**

In the State of _____**, County of** _____

_____
Reference Signature

Sworn to and subscribed before me this _____ **day of** _____**, 20**____**.**

_____
Date

_____ **(SEAL)**
Signature of Notary

My commission expires: _____

Georgia State Board of Occupational Therapy
237 Coliseum Drive
Macon, Georgia 31217-3858
Telephone: (478) 207-2440
http://sos.ga.gov/index.php/licensing/plb/36

"FORM A"

Note: Submit this form "only" if you are completing supervised clinical practice.

SUPERVISED CLINICAL EXPERIENCE (FORM A)

Instructions:
1. Please read AND refer to Board Rule 671-3-.09.

1. Applicant Name: _____

2. Agency Name:_____ Telephone No. (_____)_____

3. Agency Address: _____
Street Address

_____
City State Zip

4. Program Supervisor: _____ License No: _____

Clinical Practice –Under Direct Supervision - Supervised Clinical Practice, as used in the Law shall mean daily on-site, close contact whereby the supervisor is able to respond quickly to the needs of the client or supervisee. See Board Rules 671-2-.02 and 671-2-.03.

The applicant must submit to the board for approval each of the following:

1. A copy of the current valid license card of the licensed/certified Occupational Therapist who will supervise the clinical practice.
2. A calendar or outline of the supervised clinical practice and practice areas, including orientation, if applicable.

As Supervise Clinical Experience Coordinator, I agree that _____(name of applicant) will complete 320 hours of supervised clinical experience which meets the requirements of an accredited or approved occupational therapy or occupational therapy assistant curriculum.

Date	Signature of Supervisor **and "Active" OT License Number**
Telephone Number	Printed Name of Supervisor
Email address	Mailing Address
	City State Zip

Georgia State Board of Occupational Therapy
237 Coliseum Drive
Macon, Georgia 31217-3858
Telephone: (478) 207-2440
http://sos.ga.gov/index.php/licensing/plb/36

"FORM B"

CERTIFICATION OF COMPLETION OF SUPERVISED CLINICAL (FORM B)

I certify that _____ has satisfactorily completed a minimum of 320 hours of
(Applicant)
supervised clinical experience practice relevant to Occupational Therapy as approved by the Georgia State Board of Occupational Therapy.

The program began on_____ and was completed on_____.

EVALUATION OF APPLICANT'S ABILITY

INSTRUCTIONS:

- Please evaluate the above-named Occupational Therapy applicant present ability to function in Occupational Therapy practice.

APPLICANT'S EVALUATION:

_____

_____

_____

❒Yes ❒ No Do you recommend that the Applicant's period of supervised clinical experience meets the requirements for licensure? If "No," please explain and attach relevant documentation.

_____

_____

_____ License #: _____
(Signature of Supervisor and "Active" license number)

_____
(Printed Name of Supervisor)

Sworn to and subscribed before me this ____ day of _____, 20___.

State of _____ County of _____

_____
Notary Public

My Commission Expires: _____ (**Notary Seal)**

GEORGIA STATE BOARD OF OCCUPATIONAL THERAPY
Professional Licensing Boards
237 Coliseum Drive
Macon, GA 31217-3858

CE REPORT FORM

Continuing Education: See Board Rule 671-3-.08, regarding CE requirements on the Board website at http://sos.ga.gov/index.php/licensing/plb/36. To renew your license, you must provide documentation that you have completed the required twenty-four (24) hours of CE as stated in Board Rule 671-3-.08. PLEASE PRINT OR TYPE - Be sure to sign and date in the space provided.

Institute, Organization, Agency Conducting Program or Online Course	Title of Program or Description of Content	CE Credit Hours	Setting/Method of Program (Workshop, online, in-service)	Dates Attended

TOTAL HOURS CLAIMED _____

Attach copies of your Continuing Education Certificates. Do not send original certificates. The originals will not be returned. Please provide course outlines/description/agenda for any CE course over 4 hours.

AFFIDAVIT

I certify under penalty of perjury to the truth and accuracy of all statements, answers and representations made in this report.

(Signature of Licensed Occupational Therapist or Occupational Therapy Assistant

_____ (Printed/Typed Name)

_____ (Date)

OT/OTA License # _____ Email Address: _____

Address: _____

_____

Mail to: Georgia State Board of Occupational Therapy, 237 Coliseum Drive, Macon, Georgia 31217-3858

Consent Form

I hereby authorize the Georgia Board of Occupational Therapy to receive any Georgia criminal history record information pertaining to me which may be in the files of any state or local justice agency in Georgia.

_____
Full Name (Print)

_____
Address

_____ _____ _____ _____
Sex Race Date of Birth Social Security Number

By signing this form, I acknowledge that I have been informed of the Non-Criminal Justice Applicant's Privacy Rights and the Privacy Act Statement (Title 28 United States Code § 534) and affirm that I have retained a copy (attachments A and B) for my records.

_____
Signature

_____
Date

Special employment provisions (check if applicable):

Employment with mentally disabled (Purpose Code "M")
Employment with elder care (Purpose code "N")
Employment with children (Purpose code "W")

One of the following must be checked:

☐ This authorization is valid for 90 / 180 / _____ (circle or enter) days from date of signature.

☐ I, _____
give consent to the above named to perform periodic criminal background checks for the duration of my licensure with this state.

Attachment A

NON-CRIMINAL JUSTICE APPLICANT'S PRIVACY RIGHTS

As an applicant that is the subject of a Georgia only or a Georgia and Federal Bureau of Investigation (FBI) national fingerprint/biometric-based criminal history record check for a non-criminal justice purpose (such as an application for a job or license, immigration or naturalization, security clearance, or adoption), you have certain rights which are discussed below.

- You must be provided written notification that your fingerprints/biometrics will be used to check the criminal history records maintained by the Georgia Crime Information Center (GCIC) and the FBI, when a federal record check is so authorized.
- If your fingerprints/biometrics are used to conduct a FBI national criminal history check, you are provided a copy of the Privacy Act Statement that would normally appear on the FBI fingerprint card.
- If you have a criminal history record, the agency making a determination of your suitability for the job, license, or other benefit must provide you the opportunity to complete or challenge the accuracy of the information in the record.
- The agency must advise you of the procedures for changing, correcting, or updating your criminal history record as set forth in Title 28, Code of Federal Regulations (CFR), Section 16.34.
- If you have a Georgia or FBI criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the agency denies you the job, license or other benefit based on information in the criminal history record.
- In the event an adverse employment or licensing decision is made, you must be informed of all information pertinent to that decision to include the contents of the record and the effect the record had upon the decision. Failure to provide all such information to the person subject to the adverse decision shall be a misdemeanor [O.C.G.A. § 35-3-34(b) and §35-3-35(b)].

You have the right to expect the agency receiving the results of the criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of state and/or federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.

If the employment/licensing agency policy permits, the agency may provide you with a copy of your Georgia or FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record, information regarding how to obtain a copy of your Georgia, FBI or other state criminal history may be obtained at the GBI website (http://gbi.georgia.gov/obtaining-criminal-history-record-information).

If you decide to challenge the accuracy or completeness of your Georgia or FBI criminal history record, you should send your challenge to the agency that contributed the questioned information. Alternatively, you may send your challenge directly to GCIC provided the disputed arrest occurred in Georgia. Instructions to dispute the accuracy of your criminal history can be obtained at the GBI website (http://gbi.georgia.gov/obtaining-criminal-history-record-information).

Attachment B

PRIVACY ACT STATEMENT

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.