

\*\*\*FOR OFFICE USE ONLY\*\*\*

**Occupational Therapy Checklist**

- Endorsement       Examination
- Temporary         Grad Status
- App. & Fee
- Date: \_\_\_\_\_ Check \_\_\_\_\_
- Transcript
- Scores from NBCOT
- Lic. Verification from other States



\*\*\*FOR OFFICE USE ONLY\*\*\*

|                                  |
|----------------------------------|
| Application Approved:            |
| License Number:                  |
| Issue Date:                      |
| Grad/Temp License #:             |
| Issue Date:                      |
|                                  |
| Signature of Board Administrator |
| ID#:                             |
| Receipt #:                       |

**Rhode Island**  
**Board of Occupational Therapy**  
 Room 104  
 3 Capitol Hill  
 Providence, RI 02908-5097

***Instructions and Application For***  
**License As An**

License # \_\_\_\_\_  
 Name \_\_\_\_\_

- Occupational Therapist
- Occupational Therapy Assistant

**Endorsement** (From Another State)

Temporary Status     Yes     No

**Examination**

Graduate Status     Yes     No

**MILITARY STATUS ELIGIBILITY**

*(Documentation Required)*  
*see next page for instructions*

Please check ONE of the following criteria for expedited application:

- I am in active military duty or a reservist
- I am a military veteran with honorable discharge
- I am the spouse of someone in active military duty or the spouse of a reservist

*Applicant - Print Name*

|  |  |  |
|--|--|--|
|  |  |  |
|--|--|--|

*LAST NAME*

*FIRST NAME*

*MI*

**Phone: (401) 222-2828**

**TTY/TDD: (800) 745-5555**

**Fax: (401) 222-1272**

# LICENSURE REQUIREMENTS

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- Completed Application with Cover Page - Applications are valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you must submit a new application.
- Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of **\$140.00** and attached to the upper left-hand corner of the first (Top) page of the application. **THIS APPLICATION FEE IS NONREFUNDABLE.** Please be advised that this is an application fee and includes the first license **only** up until the next expiration date. All licenses expire biennially on June 30th of the even numbered years.
- Official transcript from an accredited School of Occupational Therapy. No student copies will be accepted.  
Scores sent directly from the National Board for Certification in Occupational Therapy (NBCOT).  
**(Telephone 1-301-990-7979)**
- If you have ever been licensed in another state, license verification(s) must be sent directly from the state(s) in which you hold or have held a license. (Interstate Verification Form included in this application can be used for that purpose)
- If applying for expedited military status, please complete the Military Expedition Form at the end of this application packet.

## **Graduate Status**

If you are a new graduate you can apply for a graduate license. These permits are valid for 90 days and may not be renewed. Failure to pass the certification exam results in the revocation of the graduate status permit. Foreign-educated graduates are not eligible for Graduate status.

- Submit this application with all requirements listed above with the exception of scores from NBCOT. If your transcript is not yet available, a certified statement may be **sent directly FROM** the Dean or Registrar of the Occupational Therapy School verifying your completion of **ALL GRADUATION REQUIREMENTS**. A completed official transcript must be **sent directly FROM the school** to the Board of Occupational Therapy as soon as it is available. A license cannot be issued without receipt of an official transcript.

## **Licensure Information**

Please visit the RIDOH website at <http://www.health.ri.gov/licenses> to Verify your license, download Rules and Regulations/Laws for your profession, download change of address forms, other licensing forms or obtain our contact information. HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others.

## **License Certificates**

RIDOH will be providing wallet license cards ONLY on issuance of licenses. If you wish to receive a license certificate, suitable for framing, please check the box below and attach a separate check in the amount of \$30.00 made payable to RI General Treasurer.

- I would like to receive a license certificate. I have enclosed a separate check in the amount of \$30.00



# State of Rhode Island Board of Occupational Therapy

## Application for License as an Occupational Therapist or Occupational Therapy Assistant

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

### 1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/Permit/Certificate. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

### 2. Social Security Number

U.S. Social Security Number

**"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Division of Taxation to verify that no taxes are owed to the State."**

### 3. Gender

 Male Female

### 4. Date of Birth

Month

Day

Year

### 5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

Zip Code

Country, if NOT U.S.

Postal Code, if NOT U.S.

Home Phone

Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

### 6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

***This address will appear on the Department of Health web site.***

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

Zip Code

Country, if NOT U.S.

Postal Code, if NOT U.S.

Business Phone

Extension

Business Fax

7. Preferred Mailing Address

Please check ONE

- Please use my Home Address as my preferred mailing address
Please use my Business Address as my preferred mailing address

8. Qualifying Education

Please list the name and information about the school that you attended that qualifies you for this license.

Form with grid for school type, name, date graduated (Month/Year), and degree received.

9. Other State License(s)

Please answer the question and list state(s), if applicable

Have you ever held, or do you currently hold, a license in another state? Yes No

If the answer to this question is 'yes', enter all other state licenses in Question 10 (below):

10. Licensure

List all states or countries in which you are now, or ever have been licensed to practice your profession.

Form with columns for State/Country and checkboxes for Active/Inactive licenses.

11. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8 1/2 x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending? Yes No

Abbreviation of State and Conviction (e.g. CA - Illegal Possession of a Controlled Substance):

Form with lines for conviction details and Month/Year columns.

12. Disciplinary Questions

Check either Yes or No for each question.

1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are formal charges pending? Yes No

2. Have you ever been denied a license, certificate, registration or permit in any state? Yes No

Note: If you answer 'Yes' to any question, you are required to furnish complete details, including date, place, reason and disposition of the matter.

**13. Affidavit of Applicant**

Complete this section and sign.

Make sure that you have completed all components accurately and completely.

I, \_\_\_\_\_, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as an Occupational Therapist/Occupational Therapy Assistant in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Occupational Therapy of any change in the answers to these questions after this application and this affidavit is signed.

Signature of Applicant \_\_\_\_\_

Date of Signature (MM/DD/YY) \_\_\_\_\_



# Rhode Island Board of Occupational Therapy

Room 104, 3 Capitol Hill  
Providence, RI 02908-5097  
(401) 222-2828

Substitute forms are not acceptable, copy this form as needed.

## INTERSTATE VERIFICATION FORM - OTHER STATE LICENSE(S)

I am applying for a license to practice as an Occupational Therapist/Occupational Therapy Assistant in the State of Rhode Island. The Rhode Island Board of Occupational Therapy requires that the following form be completed by the jurisdiction(s) in which I hold or have held a license. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Occupational Therapy at the above address.

|                               |                                 |                        |
|-------------------------------|---------------------------------|------------------------|
| _____<br>Print/Type Full Name | _____<br>Signature              | _____<br>Date          |
| _____<br>Previous Names Used  | _____<br>Social Security Number | _____<br>Date of Birth |
| _____<br>License Number       | _____<br>Date Issued            |                        |

### THIS SECTION TO BE COMPLETED BY THE OCCUPATIONAL THERAPY BOARD

|  |   |                  |
|--|---|------------------|
| Occupational Therapy Program Completed:  | Location:   | Graduation Date: |
| Licensed by Examination?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                 | Applicant has completed and passed the National Certification Exam:<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                  |
| License Status:<br><input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed | Original Date Issued:   | Expiration Date: |

**Questions:**

- Has this licensee ever been investigated by your Board?  Yes  No
- Has this licensee incurred any disciplinary proceedings in your state, or is any action pending?  Yes  No
- Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation?  Yes  No
- Do you know of any information that may discredit this person?  Yes  No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Certification:

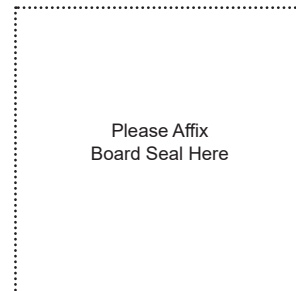
\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Type or Print Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Full Name of Licensing Board



Please Affix Board Seal Here

Please return directly to the Board at the above address. Thank you for your prompt cooperation.



## Rhode Island Department of Health Military Expedition Form

Please attach this form to the *front* of your completed application and mail to the address shown on the application cover.

Pursuant to Rhode Island General Laws § [5-88-1](#) et seq., upon application, this state may recognize occupational licenses, certificates or permits obtained from other states for military members and their spouses who relocate to this state pursuant to military orders. The Rhode Island Department of Health (RIDOH) will expedite your or your spouse's health professional license application provided the following conditions are met.

### I. PROFESSION/LICENSE TYPE

Please indicate the profession and/or license type you are applying for so that your application can be routed to the correct office:

Profession/License Type: \_\_\_\_\_

### II. MILITARY STATUS

Please check ONE of the following criteria for expedition:

I am in active military duty or a reservist.

I am the spouse of someone in active military duty or the spouse of a reservist.

I am a military veteran with honorable discharge. *You do not need to complete the rest of this application – please skip to the signature line.*

### III. PROOF OF MILITARY STATUS

Please attach a copy of proof of your military status such as one of the following: Leave Earning Statement (LES), Letter from Command, or Copy of Orders

### IV. MILITARY CHANGE OF STATION ORDER

Permanent Change of Station Order

### V. PROOF OF GOOD STANDING

Proof of good standing from the board in the other state in which the person has a license.

### VI. Criminal Background Check (a "BCI") (*unless required in the initial license application*)

BCI completed from the RI Attorney General's Office.

### VII. ATTESTATIONS:

Check all that apply:

No board in any other state has revoked the license for which I am applying as a result of negligence or intentional misconduct.

I have never surrendered an occupational license, certificate, or permit because of negligence or intentional misconduct.

I do not have a complaint, allegation, or investigation currently pending before a board in another state which relates to unprofessional conduct or an alleged crime.

I attest that the above responses and information are true and accurate to the best of my knowledge and that none of the information set forth above is false, erroneous, or defective in any important, as set forth in R.I. Gen. Laws § 11-18-1. I understand that this application is being made to the Rhode Island Department of Health, which shall rely upon my attestation and the information provided in this document.

Signature of Applicant

Date

*On a case-by-case basis RIDOH may grant a temporary license should the military member or spouse need additional time to complete education, training, and/or experience for the licensure in Rhode Island. RIDOH will contact the applicant directly should that be needed.*