



State of Ohio

Occupational Therapy, Physical Therapy, and Athletic Trainers Board
Occupational Therapy Section

Occupational Therapy Reinstatement Application Instructions

The reinstatement application applies to any individual who previously held a license to practice as an occupational therapist or occupational therapy assistant in Ohio at any time. Please review rule 4755-3-12 of the Ohio Administrative Code for clarification on the requirements to apply to reinstate your Ohio occupational therapist/occupational therapy assistant license.

Applications are reviewed on a weekly basis. All applications must be **FULLY** completed before they are reviewed and a license is reinstated. If your application remains incomplete for one year from the date the Board receives it, your file will be closed.

The Occupational Therapy Section may require the following: (1) appearance before the Section for a reinstatement interview; (2) taking or re-taking the NBCOT certification examination; and/or (3) completion of refresher coursework. You will be notified of any additional requirements after the Section reviews your application.

Each reinstatement applicant must demonstrate proof of CE completion. Any continuing education credits used to reinstate your license to active status may not be used to fulfill the continuing education renewal requirements.

You may not practice occupational therapy in Ohio until your license is reinstated.

To reinstate your Ohio license, you must complete all of the following:

(This form and instruction sheet is for your personal records.)

<p><u>Application Fee</u></p> <p><input type="checkbox"/> The application fee is \$100.00. Application fees are non-refundable. Please submit the completed "Credit Card Payment Authorization Form". Personal checks and cash <i>will not be accepted</i>.</p>
<p><u>Photograph</u></p> <p><input type="checkbox"/> Please staple a passport photograph of your face taken within the six month period immediately preceding the date of your application. The photo should be 2 x 2 inches in size. If the photo is digital, it must be a clear representation and must meet the specifications listed above. For more information please review the <i>Passport Photograph Guidelines</i> on the Board's website (http://otptat.ohio.gov).</p>
<p><u>Jurisprudence Examination</u></p> <p><input type="checkbox"/> You must score a 90% or better to pass the examination. Please download the Ohio Occupational Therapy Laws and Rules and licensure law test from the Board website.</p>
<p><u>Notarized Statement</u></p> <p><input type="checkbox"/> You must submit a notarized statement indicating why you did not renew your license by the prescribed renewal date or why you would like to reinstate your Ohio license.</p>
<p><u>Verification of Licensure</u></p> <p><input type="checkbox"/> You must provide a verification from any jurisdiction in which you currently hold or have ever held a license to practice occupational therapy or another healthcare profession. Jurisdiction means any state, U.S. territory, or foreign country.</p>
<p><u>Continuing Education</u></p> <p><input type="checkbox"/> You must provide proof of completion of 20 hours of CE, including one hour of ethics, completed in the two years</p>



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prior to the date you submit this reinstatement application. Please provide copies of your certificates of completion. Original certificates will not be returned.

Employment History Form

- You must complete and sign the employment history form.

Additional Requirements For Individuals Who Have Not Practiced Occupational Therapy

For Five Or More Years Prior to the Date of This Application:

Applicants applying for licensure by reinstatement who have not engaged in the practice of occupational therapy for more than five years prior to the date the individual applies to the Section for licensure by reinstatement may be subject to additional requirements including, but not limited to: (1) Submission of proof of completion of twenty hours of continuing education within the two year period immediately preceding the date the application is submitted; (2) Professional development plan; (3) Extended coursework; (4) Retaking and passing the NBCOT certification examination; (5) Mentorship; and (6) Competency-based performance appraisals

Please refer to the "Limited License Reference Guide" for additional information.



Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board

77 South High Street, 16th Floor
Columbus, Ohio 43215-6108

Governor
John R. Kasich
Executive Director
Jeffrey M. Rosa

Military Request Application Addendum

(This form applies to members of the armed forces, veterans, and spouses of members of the armed forces/veterans)

Please provide the First and Last Name and Social Security Number of the individual applying for the Ohio license:	
1. Have you served in the U.S. military?	Yes No
2. Has your spouse served in the U.S. military?	Yes No

If you answered No to both question 1 and 2, you are not eligible for military benefits.

3. If you answered Yes to question 2, please provide your spouse's First and Last Name:	
4. In which branch of the military did you/your spouse serve?	
5. Please provide the military service dates:	Military Service From:
	Military Service To:
6. Are you still active in the military or reserves?	Yes No
7. Were you discharged under honorable conditions?	Yes No
8. For which profession are you seeking a license?	OT OTA PT PTA AT

In addition to this application addendum, you must also submit the appropriate licensure application and a copy of your/your spouse's DD214 form or proof of current service. Please contact your County Veterans Services Office (1-877-OHIO-VET) or the Ohio Department of Veterans Services (www.ohiovet.gov) if you need assistance in obtaining a copy of the DD214 form.

You can access the licensure application at <http://otptat.ohio.gov>.

(Revised June 2014)



Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board

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Requirements for Applicants with Felony Convictions

If you are applying for licensure in the State of Ohio and you were convicted of a felony, you must provide the Board with a signed statement describing the details of the event(s) that led to the felony conviction and certified copies of the following court records:

1. Indictment
2. Plea Entry
3. Disposition
4. Sentencing Entry
5. Terms of Parole or Probation
6. Parole or Probation Release/Discharge

Failure to provide these documents will result in a delay in the processing of your applications. If you have any questions about this requirement, please contact the Board at 614-466-3774 or board@otptat.ohio.gov.



The Occupational Therapy Section

Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board
 77 South High Street, 16th Floor
 Columbus, Ohio 43215-6108

Phone (614) 466-3774 Fax (614) 995-0816
 Website: <http://otptat.ohio.gov>
 Email: board@otptat.ohio.gov

<p>OHIO OCCUPATIONAL THERAPY REINSTATEMENT APPLICATION</p> <p>(Select one)</p> <p><input type="radio"/> Occupational Therapist</p> <p><input type="radio"/> Occupational Therapy Assistant</p>

INSTRUCTIONS, PLEASE READ:

- A. Complete all relevant categories (type or print in ink).
- B. Photo must be submitted with this application.
- C. Fee must be submitted with application.

ALL LICENSURE APPLICATION FEES ARE NON-REFUNDABLE

****PLEASE READ:** Provision of your social security number is mandatory and may be provided for child support enforcement purposes (ORC 3123.50) and for reporting requirements to the Federal Healthcare and Integrity Protection Data Bank (42 USC 132a-7e, 5 USC 552a, 45CFR pt. 61). In compliance with section 1347.05 (E) of the Revised Code, you are notified that failure to supply the information requested in this application may result in a denial of the application.

Section A: IDENTIFICATION INFORMATION			
First Name	Middle Name	Last Name	Maiden Name
Home Phone Number (with Area Code)		Work or Alternate Phone Number (with Area Code)	
Permanent Mailing Address			
City	State	Zip	County
**Social Security Number		Email Address (Optional)	
Date Of Birth (mm/dd/yyyy)		Place Of Birth (City and State)	
Color of Hair		Color of Eyes	Gender <input type="radio"/> Male <input type="radio"/> Female
According to rule 4755-3-08 of the Ohio Administrative Code, you must inform the Occupational Therapy Section in writing of any change of name, address, or employment within thirty days after the change.			

Staple Passport Photograph Here

Photograph must be 2 x 2 inches in size, full face, front view, between 1 inch and 1 3/8 inches from the bottom of the chin to the top of the head. Background color white, off-white, or light blue. Photograph must be taken with the past 6 months. Sign back of photograph.

FOR OFFICE USE ONLY
Application Received
Amount \$:
Payment Details:
Batch Number

Section B: EDUCATION

Entry Level Occupational Therapy Education

Name and Location (City, State)	Certificate/ Degree	Dates Attended (MO/YR)	
		From	To

Other Post High School Education

Please list all post-professional education and/or other colleges attended.

Name and Location (City, State)	Certificate/ Degree	Dates Attended (MO/YR)	
		From	To

Section C: EXPERIENCE

(Starting with present position, list chronologically your work experience during the past ten years. Please attach a separate page if necessary.)

DATES (MO/YR)		JOB TITLE, TYPE OF PRACTICE AND AVERAGE WORK HOURS PER WEEK	NAME AND ADDRESS OF EMPLOYER	PERFORMED OT DUTIES IN OHIO	
Start	End			YES	NO

Section D: LICENSURE HISTORY

Do you currently hold or have ever held a license, certification, or registration to practice occupational therapy or another healthcare profession in this state and/or another state. YES NO

If YES, Please complete the table below.

Initial license to practice as an Occupational Therapist Occupational Therapy Assistant issued by which State?

STATE	LICENSE #	ISSUE DATE	EXPIRATION DATE

Section E: BACKGROUND QUESTIONS

Answer the following questions by initialing in the appropriate space at the right.

NOTE: Be advised that you are under a continuing obligation to supplement your answers to these questions should any answers change following the submission of this application.

	YES	NO
1. Have you ever been convicted of, found guilty of, pled guilty to or received treatment in lieu of conviction for a felony and/or any offense involving moral turpitude in Ohio, another state, or a US territory?		
2. Have you ever been adjudged by a court, in Ohio, another state, or a US territory to be incompetent?		
3. Have you ever been denied licensure to practice as an occupational therapist or occupational therapy assistant, or another healthcare profession in Ohio, another state, or US territory?		
4. Have you ever been disciplined in any state or US territory in which you have ever held a license to practice as an occupational therapist or occupational therapy assistant, or any other healthcare profession?		
5. Have you used drugs, narcotics, or alcohol to the extent that it impairs you ability to practice occupational therapy or another healthcare profession?		
6. Have you ever been convicted of a misdemeanor when the act that constituted the misdemeanor occurred during the practice of occupational therapy?		

If the answer to any questions is "yes", please provide a written statement explaining the incident(s) and what state it occurred in and attach supporting documentation including but not limited to: *court records, police records, and/or documentation from other state licensing boards.* . If you have been convicted of a felony, you must provide "certified "copies of the following court documents: *Indictment, Plea Entry, Disposition, Sentencing Entry, Terms of Parole or Probation, Parole or Probation and Release/Discharge*

SECTION F: ANTICIPATED PLACE OF EMPLOYMENT

If unknown at the time this application is completed, please put "Unknown")

Facility Name	Employment Starting Date
Facility Physical Address (include City, State, and Zip)	Title/Position
Name of Supervising Occupational Therapist	License Number
	Phone Number w/Area Code

SECTION G: CERTIFICATION OF APPLICANT

The section must be sworn to in the presence of a Notary Public or an officer authorized to administer oaths.

I, _____, certify that I am the person referred to in this application and that the foregoing statements are true in every respect, and that the attached photograph is a true likeness of myself.

I hereby authorize all my references; educational institutions; employers; business; professional organizations and associates - past, present, and future- to release to the Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board any information requested by the Board in connection with the processing of this application or subsequent licensure.

In accordance with the Revised Code, section 1347.05(E) you are notified that failure to supply the information requested on the application may result in denial of the application.

I hereby certify to the Occupational Therapy Section that I am not presently functioning and will not function as an Occupational Therapist or Occupational Therapy Assistant or use any titles or initials to indicate or imply that I am licensed in Ohio to perform occupational therapy services until I receive a full license from the OT/PT/AT Board.

I further certify that if I accept employment as an OT/OTA, I will only perform duties in accordance with the laws and rules governing occupational therapy practice in the State of Ohio.

I understand the Board is authorized to investigate persons whom they have reason to believe are unlawfully practicing occupational therapy.

I further understand that pursuant to section 4755.11 of the Ohio Revised Code, the Occupational Therapy Section may suspend, revoke, or refuse to issue or renew the license of an individual who has violated any of the laws and rules governing occupational therapy in the State of Ohio.

Signature of Applicant

Date

SECTION H: Notary Public please complete the following:

Subscribed and sworn to in my presence this _____ day of _____, Year _____.

Signature of Notary

Date Commission Expires

Return This Document To:

Ohio OT PT AT Board
77 South High Street, 16th Floor
Columbus, OH 43215-6108

Notary Seal



State of Ohio

Occupational Therapy, Physical Therapy, and Athletic Trainers Board

Credit Card Payment Authorization Form

Credit card payments may be mailed, faxed, emailed, or phoned in to the Board office. **This document will be shredded after your payment is processed.**

Section I: Provide Credit Card Information		
Card Holder Name: (Print First and Last Name)		
Mailing Address, including City, State, and Zip Code:		
Phone Number w/ Area Code:	Email Address (for receipt):	
Credit Card Type: <input type="radio"/> Master Card <input type="radio"/> Visa	Credit Card Number	
Credit Card Expiration Date	CVV2/CID# (The three digit number on back of card):	Payment Amount (\$0.00):
Section II: Provide Payment Information		
Name of Applicant, if different than card holder name (Print First and Last Name):		
Specify License Type: <input type="radio"/> OT <input type="radio"/> OTA <input type="radio"/> PT <input type="radio"/> PTA <input type="radio"/> AT License Number (i.e. AT.000000) if applicable: _____		
Payment for: <input type="radio"/> Examination Application <input type="radio"/> Endorsement Application <input type="radio"/> Reinstatement Application <input type="radio"/> Restoration Application <input type="radio"/> Renewal <input type="radio"/> CE Application <input type="radio"/> Duplicate Wall Certificate <input type="radio"/> License Verification <input type="radio"/> Fine		

Signature

Date

Return This Document To:

Ohio OT PT AT Board
77 South High Street, 16th Floor
Columbus, OH 43215-6108

Phone (614) 466-3774

Fax (614) 995-0816

Email board@otptat.ohio.gov



State of Ohio

Occupational Therapy, Physical Therapy, and Athletic Trainers Board

Passport Photograph Guidelines

The Ohio OTPTAT Board accepts passport photographs that meet the US Passport Guidelines established by the U.S. Department of State's Passport Services Directorate. For additional information on the photograph preparation requirements contained in the US Passport guidelines please visit the U.S. Department of State's travel information website (<http://travel.state.gov>).

Photograph Positioning and Background

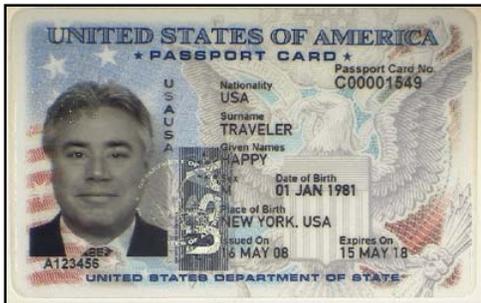
1. Frame subject with full face, front view, eyes open
2. Make sure photo presents full head from top of hair to bottom of chin; height of head should measure 1 inch to 1-3/8 inch (25 mm to 35 mm)
3. Center head within frame (see page 2)
4. Make sure eye level is between 1-1/8 inch and 1-3/8 inch (28 mm and 35 mm) from bottom of photo
5. Photograph subject against a plain white or off-white background
6. Position subject and lighting so that there are no distracting shadows on the face or background
7. Encourage subject to have a natural expression

Photograph Print Properties

Produce 2 inch x 2 inch (51 mm x 51 mm) color photo. Print photo on thin photo paper or stock. Ensure the print is clear and has a continuous tone quality. Do not retouch or otherwise enhance or soften photo.

The following pages were taken from the U.S. Department of State's website (<http://travel.state.gov>).

Passport Book & Card Photograph Quality Requirements



In order to print your passport picture, clear and correctly exposed photos must be submitted with your application – especially when applying for the U.S. passport card which displays a black and white image of the bearer. See the following examples of acceptable and unacceptable photos to ensure that the photographs you submit are correct.

The **most common** reason for a passport photo to be rejected for use is the **over exposure** or **lightness** of the photograph.

Photographs should be **2 x 2 inches** in size. The face size, measured from the bottom of the chin to the top of the head (including hair), should not be less than 1 inch or more than 1 3/8 inches.

Photo 1 is not acceptable because it is **over exposed**, as you can see from the light patches discoloring the woman's face.

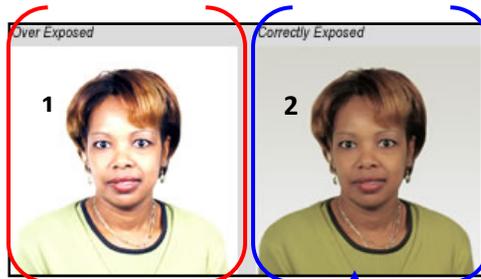
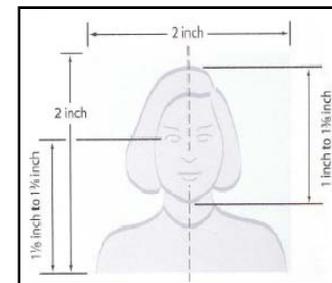


Photo 2 is acceptable



Other examples of **unacceptable** and **acceptable** passport photographs include:

Shadows on Face



Poorly Focused



Low Quality/Visible Dots



Incorrect
Facial
Direction



Dark
Photo



Passport and Visa Digital Image Requirements and Specifications

The submitted digital face image must adhere to the following specifications. Please be advised that **failure to comply with any of the following requirements may result in rejection of your image by the online image quality assessment test or by a human reviewer.**

Examples of well-composed images



Image Requirements – Technical Specifications	
Acquisition	The image file may be produced by acquiring an image with a digital camera or by digitizing a paper photograph with a scanner .
Dimensions	Image pixel dimensions must be in a square aspect ratio (meaning the height must be equal to the width). Minimum acceptable dimensions are 600 pixels (width) × 600 pixels (height) . Maximum acceptable dimensions are 1200 pixels (width) × 1200 pixels (height) .
Color	Must be in color (24 bits per pixel) in sRGB color space (common output of most digital cameras).
File Format	Must be in the Joint Photographic Experts Group (JPEG) file interchange format (JFIF).
File Size	Must be less than or equal to 240 kilobytes .
Compression	The image may need to be compressed in order for it to be under the maximum file size. The compression ratio used should be less than or equal to 20:1.
Additional requirements if scanning:	
Print Size	If scanning the image from a paper photograph, the size of the paper photograph should be at least 2 inches × 2 inches (51 mm × 51 mm) square.
Resolution	Printed photographs should be scanned at a sampling frequency of at least 300 pixels per inch.
Image Requirements – Composition	

Content	<ul style="list-style-type: none"> • The image must contain the full face, neck, and shoulders of the applicant in frontal view with a neutral, non-smiling expression and with eyes open and unobstructed and directed at the camera. • All facial features must be visible and unobstructed. • No extraneous objects, additional people, parts of the body below the applicant's shoulders, or other artifacts. • The image must be from a recent (within 6 months) photo of the applicant.
Head Size	<ul style="list-style-type: none"> • The head height or facial region size (measured from the top of the head, including the hair, to the bottom of the chin) must be between 50% and 69% of the image's total height. • The eye height (measured from the bottom of the image to the level of the eyes) should be between 56% and 69% of the image's height.
Head Orientation	<ul style="list-style-type: none"> • Subject must directly face the camera. • Head must not be tilted up, down, to the side, or toward the shoulders. • Head must be centered within frame.
Background	<ul style="list-style-type: none"> • Subject must be surrounded by a plain, light-colored background with no distracting shadows on the subject or background.
Focus	<ul style="list-style-type: none"> • The entire face must be in focus and not overly-sharpened.
Brightness/ Contrast	<ul style="list-style-type: none"> • Brightness and contrast should represent subject accurately.
Color	<ul style="list-style-type: none"> • Image must be in color (24 bits per pixel). • Black and white photos are not acceptable. • Color should reproduce natural skin tones. • Color must be continuous tone – no posterization.
Exposure/ Lighting	<ul style="list-style-type: none"> • Photo may not be over- or under-exposed.

	<ul style="list-style-type: none"> • Avoid shadows on face or background.
Resolution	<ul style="list-style-type: none"> • Fine facial features should be discernible. • No discernible pixels/pixelization, graininess, or dot patterns.
Compression	<ul style="list-style-type: none"> • Image must not be overly compressed (the compression ratio used should be less than or equal to 20:1).
Alteration	<ul style="list-style-type: none"> • Digital enhancement or other alterations or retouching are not permitted. • When resizing, the aspect ratio of the image must be preserved (no image stretching is allowed).
Eyeglasses	<ul style="list-style-type: none"> • Eyeglasses are acceptable in photo only if the lenses are not tinted and there is no glare, shadows, or rims/frames obscuring the eyes. Glare on eyeglasses can usually be avoided by a slight upward or downward tilt of the head. • Dark glasses or nonprescription glasses with tinted lenses are not acceptable unless you need them for medical reasons.
Decorative Items	<ul style="list-style-type: none"> • No sunglasses or other items that obscure the face. • Hats or head coverings are only allowed if worn for religious reasons AND if they do not obscure any facial features.



State of Ohio

Occupational Therapy, Physical Therapy, and Athletic Trainers Board

Employment History

This form is MANDATORY for Reinstatement Applicants

This form must be completed by any person who is applying to reinstate an Ohio license. Attach additional sheets if necessary. **If this form is not complete in its entirety, your application will not be processed and this form will be returned to you for completion.**

Section A

1. What type of license are you applying to reinstate? (Please provide Ohio license number)	
<input type="radio"/> OT # _____	<input type="radio"/> PT # _____
<input type="radio"/> AT # _____	<input type="radio"/> OTA # _____
<input type="radio"/> PTA # _____	
2. When did you discover your license expired (please list a specific date)?	
3. How did you discover your license expired?	
<input type="radio"/> Board letter	<input type="radio"/> Employer discovered
<input type="radio"/> Other, Explain	
4. Have you provided treatments to patients/clients as an OT, OTA, PT, PTA, or AT <u>in Ohio</u> since your license expired?	
<input type="radio"/> Yes	<input type="radio"/> No (If no, complete section D.)
5. If "yes" to question 4, were you employed by a contract company/agency?	
<input type="radio"/> Yes (If yes, complete sections B, C, and D.)	<input type="radio"/> No (If no, complete sections C and D.)

Section B

If you were employed by a contract company/agency, you are required to list the details for each facility in Ohio where you provided OT, OTA, PT, PTA, or AT services, including the name of each person who supervised you and the dates you provided services at each facility.

Name of Contract Company/Agency:

Address, City, State, Zip Code:

Phone Number w/ Area Code:

Supervisor(s) Name, Title, License Number(s):

Section C

Employment Information-If you worked for a contract company, list the facility(s) where you provided services in this section.*

Employer #1: (Company or Facility Name)

Address, City, State, Zip Code:

Phone Number w/ Area Code:

Supervisor(s) Name, Title, License Number(s):

List the specific date(s) you provided services at this facility ***(Only list the dates you practiced at this facility after your licensed expired):**



State of Ohio

Occupational Therapy, Physical Therapy, and Athletic Trainers Board

Employment History

This form is MANDATORY for Reinstatement Applicants

Employer #2: (Company or Facility Name)	
Address, City, State, Zip Code:	
Phone Number w/ Area Code:	Supervisor(s) Name, Title, License Number(s):
List the specific date(s) you provided services at this facility *(Only list the dates you practiced at this facility <u>after your licensed expired</u>):	

Employer #3: (Company or Facility Name)	
Address, City, State, Zip Code:	
Phone Number w/ Area Code:	Supervisor(s) Name, Title, License Number(s):
List the specific date(s) you provided services at this facility *(Only list the dates you practiced at this facility <u>after your licensed expired</u>):	

Section D

I, the undersigned, hereby certify that the information provided on the employment history form is accurate to the best of my knowledge.

Print Name

Type of License (OT, OTA, PT, PTA, AT)

Signature

Date

Return This Document To:
Ohio OT PT AT Board
77 South High Street, 16th Floor
Columbus, OH 43215-6108



State of Ohio

Occupational Therapy, Physical Therapy, and Athletic Trainers Board

Verification of Licensure

This form must be completed by an official from each jurisdiction where the applicant currently holds or has ever held a license, certification, or registration to practice an occupational health profession. Jurisdiction means any state, U.S. territory, or foreign country. You may copy this form and forward it as needed. Please contact each state directly to determine their license verification process.

This section must be completed by the applicant. Please print or type.		
Name (First, Middle, Last):		Maiden Name:
Name as it appears on this state's license, certificate, registration, or permit:		
Type of License/Certificate/Registration/Permit: <input type="radio"/> OT <input type="radio"/> OTA <input type="radio"/> PT <input type="radio"/> PTA <input type="radio"/> AT <input type="radio"/> Other _____	Jurisdiction	License Number
Social Security Number:	Date of Birth (mm/dd/yyyy):	

The Ohio OT PT AT Board requests that I submit evidence of my license/certification/registration/permit in your jurisdiction. You are hereby authorized to release any information in your possession pertaining to me directly to the Ohio OT PT AT Board, 77 South High Street, 16th Floor, Columbus, Ohio, 43215-6108.

Applicant Signature

Date

This section must be completed by an administrative officer of the regulatory agency. Please print or type.			
Licensure Jurisdiction:	License Number:	Original Issue Date:	Expiration Date:
Current Licensure Status: <input type="radio"/> Active <input type="radio"/> Inactive/Expired <input type="radio"/> Suspended/Revoked <input type="radio"/> Other (Explain)			
The license was issued on the basis of: <input type="radio"/> Examination <input type="radio"/> Endorsement <input type="radio"/> NBCOT or BOC <input type="radio"/> Grandfather <input type="radio"/> Other (Explain)			
Has the applicant's license to practice ever been restricted or disciplined in any way? If yes, please explain and attach any relevant documentation.			
Does the applicant have any pending complaints or is the applicant currently under investigation? If yes, please explain and attach any relevant documentation.			

Print Name

Title

Signature

Date

Return This Document To:

Ohio OT PT AT Board
77 South High Street, 16th Floor
Columbus, OH 43215-6108

Board Seal



State of Ohio

Occupational Therapy, Physical Therapy, and Athletic Trainers Board

Occupational Therapy Continuing Education Reporting Form

Full Name _____

License Number: OT/OTA _____

- A. Presentations of occupational therapy programs, workshops, or seminars
- B. Preparation to teach a clinical course in occupational therapy
- C. Supervision of fieldwork

(A maximum of 8 hours may be earned in each of these categories)

Name of Course/Activity	Date	# of Hours

Research Projects

(A maximum of 10 hours may be earned in this category)

Name of Research Project/Activity	Date	# of Hours

Informal Independent Study

(A maximum of 4 hours may be earned in this category)

Name of Informal Independent Study/Activity	Date	# of Hours

Applicant's Signature

Date

Return This Document To:
Ohio OT PT AT Board
77 South High Street, 16th Floor
Columbus, OH 43215-6108
(614) 995-0816 (Fax)



State of Ohio

Occupational Therapy, Physical Therapy, and Athletic Trainers Board
Occupational Therapy Section

Occupational Therapy Jurisprudence Examination Instructions

The Ohio OT Jurisprudence Exam is open book. You will need to download the Ohio Occupational Therapy Practice Act (Laws and Rules) before beginning this examination.

1. You will need to create a user profile to access the online Ohio OT Jurisprudence Exam. To create a user profile, click on the "New User" link in the upper right hand corner of the page accessed at the link below and complete the required information. The accuracy of this information will help ensure that the Board can match your exam results to your license application and/or your Ohio license.
2. On the Course Catalog page, select the box in the Enroll column next to the appropriate exam and click on the "Order now" button.

* Please select the "**Ohio OT Jurisprudence Exam For Licensure Applicants**" on the Course Catalog page if you are taking the exam as part of your licensure application.

* Please select the "**Ohio OT Jurisprudence Exam for CE Credit**" on the Course Catalog page if you are taking the exam for continuing education credit.

There is no additional fee to take the Jurisprudence Exam.

3. Once you complete the exam, you will see your score and will be prompted to send transcripts. The Board will automatically receive a copy of the transcript that you send to yourself. Make sure to: (1) check the box to add the course to your transcript; (2) enter your email address in the "E-mail Transcripts to:" box; (3) preview the transcript; and (4) send the transcript.

Please do not forget to request that the transcript be sent.

The Ohio OT Jurisprudence Exam can be accessed at <https://ohiootptatboard.mycourse.com>.

Occupational Therapy Section Limited License Reference Guide

Additional requirements for individuals who have been out of practice for five or more years include: (1) Additional continuing education; (2) Competency-based performance appraisals; (3) Mentorship; (4) Professional development plan; (5) Extended coursework; and (6) Retaking and passing the NBCOT certification examination.

Out of practice is defined as “being actively engaged in the practice of occupational therapy for fewer than two hundred fifty (250) hours over the five year period prior to the date the applicant submits the licensure application.

OT/OTA Out of practice for 5 years or more

Step 1:

1. Completion of AOTA CE Course titled
“Exploring the Occupational Therapy Practice Framework: Domain and Process, 3rd Edition Short Course”

Step 2:

Primary Option: Retake NBCOT Certification Examination within 6 months of date of Limited License (LTD) agreement. Full, unrestricted license issued upon passage of NBCOT exam.

Alternate Option: Issuance of Limited License Followed by Supervised Practice:

- a) 320 hours/first 6 months of licensure; 8 hours of supervision per week must be direct supervision.
- b) AOTA Fieldwork Performance Evaluation at midterm and final rating/ must be completed by supervising OT within 30 days upon completion of supervised practice hours.
- c) Log of supervised clinical practice, which shall include the date, signature of the primary/non-primary supervising occupational therapist/occupational therapy assistant, and number of hours supervised.

The deadline to complete the terms of the limited license agreement is 12 months from the date of the limited license letter.

The Section will take into consideration the length of time the individual practiced prior to not working, prior practice settings, specialties/certifications maintained while practicing, and/or how the individual kept up with the practice of occupational therapy while they were out of practice.