2013 - 2014
APPLICATION FOR ANNUAL LICENSE RENEWAL TO PRACTICE OCCUPATIONAL THERAPY IN THE STATE OF NORTH CAROLINA

Mailing Address: NCBOT, PO Box 2280, Raleigh, NC 27602

Applications must be typed or printed in ink and submitted with a $50.00 non-refundable check made payable to NCBOT and a 2013-2014 Continuing Competence Activity Record if you are completing your application on paper. ***Incomplete or partial applications will be returned.***

NORTH CAROLINA LICENSE NUMBER : _____ ☐ OT/L ☐ OTA/L

PERSONAL INFORMATION:

Last Name _____ First _____ Middle/Maiden _____

Mailing Address _____

City _____ County _____ State _____ Zip _____

Social Security # XXX-XX-_____ Home Phone (_____) _____Cell Phone (_____) _____

Email Address _____

WHERE DO YOU WORK IN NORTH CAROLINA?

Employer _____

Physical Address _____

City _____ County _____ State _____ Zip _____

Work Phone (_____) _____

DOES THIS REFLECT:		DATE OF CHANGE
Name Change? *See back page for acceptable documentation for name change*	_____Yes	_____
Address Change?	_____Yes	_____
Employment Change?	_____Yes	_____

OT EDUCATION INFORMATION: Data in this section is used by the Cecil G. Sheps Center for Health Services Research for use in the NC Health Professions Data Book

University/College: _____ State: _____

OT Degree Earned: ☐ Doctoral ☐ Masters ☐ Bachelors ☐ Associates ☐ Other

Year Graduated: _____

EMPLOYMENT INFORMATION:

- ☐ Full-time in OT Field
- ☐ Part-time in OT Field
- ☐ Employed in other field/plan to return to OT
- ☐ Employed in other field/do NOT plan to return to OT
- ☐ Unemployed/seeking employment in OT field
- ☐ Unemployed/NOT seeking employment in any field
- ☐ Retired
- ☐ Other

PRACTICE SETTING: (Choose only one)

- ☐ Academic
- ☐ Administration
- ☐ Hospital (non-mental health)
- ☐ Long-Term Care/ALF/SNF
- ☐ Freestanding Outpatient Clinic
- ☐ Home Health
- ☐ Mental Health
- ☐ Private Practice
- ☐ Research
- ☐ School System
- ☐ Traveler
- ☐ Other

CONTINUED ON BACK

PRACTICE SPECIALTY: (Choose only one)

- ☐ Acute Care
- ☐ Administration
- ☐ Developmental Disabilities
- ☐ Education
- ☐ Geriatric
- ☐ Hand Rehab
- ☐ Home Health
- ☐ Pediatrics
- ☐ Physical Disabilities
- ☐ Schools/Early Intervention
- ☐ Sensory Integration
- ☐ Technology
- ☐ Other

HOURS REGULARLY WORKED PER WEEK: ☐ Not Employed ☐ 20 or less ☐ Between 21–39 ☐ 40 or more

RACE/ETHNICITY: (Optional/For Statistical Purposes Only):

- ☐ African-American/Non-Hispanic
- ☐ American Indian/Alaskan Native
- ☐ Asian/Pacific Islander
- ☐ Hispanic
- ☐ Multiracial
- ☐ White/Non-Hispanic
- ☐ Other

DATE OF BIRTH: ____/_____/_____

IF YOU ANSWER "YES" TO ANY QUESTION BELOW, A DETAILED LETTER OF EXPLANATION ALONG WITH THE DOCUMENTATION INDICATED AFTER EACH QUESTION MUST BE SUBMITTED. (This Information is not shared with the Sheps Center for Health Services Research.)

1. Since the last renewal of your license have you been convicted or plead guilty or no contest to a felony or any crime, such as fraud, that involves moral turpitude? **If so, request a criminal records check be sent by the appropriate entity directly to the Board.** ☐ Yes ☐ No
2. Since the last renewal of your license have you had a license denied, restricted or disciplined by any other licensing board or national certifying body? **If so, send a request to the board/body where your disciplinary action occurred for a copy of the decision to be sent directly to the Board.** ☐ Yes ☐ No
3. Since the last renewal of your license have you had any involvement in a civil lawsuit arising out of or related to your practice of occupational therapy? **If so, send details of the civil lawsuit to the Board.** ☐ Yes ☐ No
4. Do you currently have, or since the last renewal of your license have you had, any mental, emotional, and/or physical disease or condition, including alcohol or other substance abuse, that may presently interfere with your ability to competently and safely perform the essential functions involved in the practice of the profession? ☐ Yes ☐ No
5. Since the last renewal of your license have you been addicted to, or used in excess, any drug or chemical substance, including alcohol, or been treated for a drug or alcohol addiction or participated in a rehabilitation program? ☐ Yes ☐ No

I hereby affirm that I have read all questions on this renewal application and have answered truthfully, accurately and completely. I hereby acknowledge that failure to answer these questions truthfully, accurately and completely shall constitute cause for the initiation of disciplinary action against my North Carolina license. I also affirm that I have read and comply with the North Carolina Occupational Therapy Practice Act and Rules of the Board. **Unsigned applications are incomplete and will be returned. In order for this renewal to be considered "on time" all required forms and fees must be complete and postmarked by June 30. Licenses are not considered renewed until processed by the Board office.**

Signature _____ Date _____

Occupational Therapy Assistants must provide a signature from at least one of their supervising occupational therapists. (No OT supervisor signature is required if you are not employed as an OTA.)

I certify that I am providing supervision for the above-named Occupational Therapy Assistant

Signature of Supervising OT/L: _____ License #_____

Phone # of Supervising OT/L: (_____)_____ Date _____

*Acceptable documentation for a name change includes a copy of your marriage license or court documents relating to divorce or legal change of name. A copy of your driver license or social security card is not acceptable.

Please note: **Licenses not renewed by June 30 are expired.** There is no "inactive status." Your license is either current or expired. If you choose to renew your license within 24 months of the expiration date, **you will still be required to complete the continuing competence requirements and pay the renewal fees** for the period of time your license was not current, along with any applicable late fee.