STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

CALIFORNIA BOARD OF OCCUPATIONAL THERAPY
2005 Evergreen Street, Suite 2050, Sacramento, CA 95815-3831
T: (916) 263-2294 F: (916) 263-2701
E-mail: cbot@dca.ca.gov Web: www.bot.ca.gov

APPLICATION FOR ADVANCED PRACTICE APPROVAL – *SWALLOWING ASSESSMENT, EVALUATION, OR INTERVENTION.*

(Please read the *Information and Instruction Sheet* before completing the application. Print clearly or type all information.)

Section I: Personal Data (Please Complete All Boxes)

A. Last Name		B. First Name		C. Middle Name
D. Residence Address (Street No., Apt No.)		City	State	Zip Code
E. OT License No.	F. Home Telephone No. ( )	G. Business Telephone No. ( )	H. E-Mail Address	
I. Current Employer		J. Supervisor First Name	K. Supervisor Last Name	

Section II: Affidavit

I hereby declare that I am the person named in this application and that I have read the complete application and know the contents thereof. **I declare, under penalty of perjury of the laws of the State of California, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct.** I understand that falsification or misrepresentation of any item or response on this application or any attachment hereto, is sufficient grounds for denial, suspension or revocation of a license to practice as an occupational therapist in the State of California.

_____ _____

Signature of Applicant Date

Information Collection and Access – The Board's executive officer is the person responsible for information maintenance. Business and Professions Code section 2570.18 gives the Board authority to maintain information. All information is mandatory. Failure to provide any mandatory information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for advanced practice approval. Each individual has the right to review his or her file maintained by the agency subject to the provisions of the California Public Records Act.

Approval in an advanced practice area demonstrates entry-level competency in the area approved. Approval does not represent expertise in this area and should not be misrepresented as such. Pursuant to Title 16, California Code of Regulations, Section 4170(f)(1) of the Ethical Standards of Practice, occupational therapists are required to accurately represent their credentials, qualifications, education, experience, training, and competency. Further, Section 4170(d) states that occupational therapists shall perform services only when they are qualified by education, training, and experience to do so.

Section III: POST PROFESSIONAL EDUCATION AND TRAINING SUMMARY SHEET – <u>SWALLOWING ASSESSMENT, EVALUATION AND INTERVENTION:</u>

SWALLOWING ASSESSMENT, EVALUATION OR INTERVENTION EDUCATION
(Minimum of 45 Contact Hours Required):

# of Hours:	Course Title:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	Total Contact Hours

SWALLOWING ASSESSMENT, EVALUATION AND INTERVENTION TRAINING
(Minimum of 240 Supervised Hours Required):

# of Hours:	Name of Facility:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	Total Supervised Hours

Please Note: If you use electrical stimulation as part of your swallowing assessment, evaluation, or intervention treatment, you must also comply with the requirements for physical agent modalities.

Section IV: Post-Professional Education (Copy this form and use a separate form for each course.)

Name of Course: _____

Number of Contact Hours: _____

Name of Course Provider: _____

Date Completed: _____

Course(s) must have been completed within the past five (5) years.

(Courses older than 5 years will not be counted toward the educational requirement)

Required content areas – Please indicate the areas covered by the above-named course:

☐ Anatomy, physiology and neurophysiology of the head and neck with focus on the structure and function of the aerodigestive tract.

☐ The effect of pathology on the structures and functions of the aerodigestive tract including medical interventions and nutritional intake methods used with patients with swallowing problems.

☐ Interventions used to improve pharyngeal swallowing function.

A Copy of Certificate of Completion must be attached for <u>each</u> course.

Section V: Post-Professional Training (Copy this form and use a separate form for each training and/or affiliation.)

NOTE TO SUPERVISOR: You are being asked to provide information for an OT seeking approval to provide swallowing assessment, evaluation or intervention. Please complete this form and return it to the OT so that it can be included in his/her application packet.

This training represents _____ hours of experience in ***Swallowing assessment, evaluation or intervention*** acquired between _____(month/day/year) and _____ (month/day/year).

Supervisor's Name: _____
First Last

License Type/Number: _____ Supervisor's Phone #: _____
e.g., OT, SLP, MD

Name and Address of Facility
Where Training Occurred: _____

_____

Is _____ **competent in providing swallowing assessment,**
OT applicant's name

evaluation, or intervention?

☐ YES, competence has been demonstrated swallowing assessment, evaluation or intervention.
☐ NO, the OT has not demonstrated competence in swallowing assessment, evaluation or intervention.

Please identify the knowledge, skills and abilities demonstrated by the OT:

_____

_____

_____

_____

By signing below, YOU certify that you were the clinical supervisor for training hours noted above and that the timeframes and hours listed are true and correct.

Supervisor's Signature:_____Date: _____

Note to Supervisor:

- Until the Board approves this applicant, you have continuing supervisory responsibility *even if the "training" period has ended*, IF the OT is providing swallowing assessment, evaluation or intervention, and you are both employed at the location named above.