Heath Occupations Program
Attn: OTA Licensing
P.O. Box 64882
St. Paul, MN 55164-0882
(651) 201- 3724

(For MDH office Use Only)

Application for Temporary License: Occupational Therapy Assistant New Graduate

NOTICE TO APPLICANTS: This notice is given pursuant to Minnesota Statutes, §13.04, Subd. 2, and §13.41, Subd. 2. The Commissioner of the Minnesota Department of Health (Commissioner) will use information provided in this application to determine if you meet Minnesota Statutes Section §148.6401 to 148.6450 requirements for a license. You are not legally required to supply the requested information. However, FAILURE TO PROVIDE INFORMATION OR THE SUBMISSION OF FALSE OR MISLEADING INFORMATION MAY DELAY THE PROCESSING OF YOUR APPLICATION OR MAY BE GROUNDS FOR DENYING YOUR APPLICATION. All data, except your name and address, submitted by you or on your behalf are considered private until you are licensed. "Private" data is data that is not public and is accessible to you. When you become licensed the application data becomes public. Information submitted to the Commissioner in this license application may, in some circumstances, be disclosed to other persons or entities including the Minnesota Department of Health and its staff, the Occupational Therapy Practitioners Advisory Council, staff of the Attorney General's office; and persons whom they contact including any person to whom the Commissioner must refer the application or parts thereof for verification purposes or for otherwise determining your qualifications, and to persons you designate. In addition, if the matter of your license becomes contested and thereby results either in a contested case hearing or litigation, the data submitted by you or on your behalf may also become accessible to the Minnesota Office of Administrative Hearings, appropriate courts, and those associated with such proceedings, and thereby become public data.

PART I. To be completed by Applicant

Application for a Temporary License as: ____ Occupational Therapy Assistant (OTA)
Do you have a MN OTA temporary license? YES_____ NO _____ Credential#_____
Is this a renewal of your OTA temporary license? YES_____ NO_____ MN OTA License Number_____
Are you adding an additional Supervisor to your current employment and temporary OT license? YES_____ NO_____
Are you adding an additional work location? YES_____ NO_____
Are you adding an additional employer and supervisor? YES_____ NO_____

Name, City and State of school from which you graduated_____ Date_____

Please designate with an "X" one address you designate for receive correspondence from the Department regarding your license and which will be public information: HOME_____EMPLOYER_____

PLEASE PRINT IN INK

Applicant Name_____
Last Name First Name Middle Name

Home Address: _____
Street (PO Box is not acceptable as home address) City State Zip

Home Telephone: _____ Cell Phone: _____

Email Address:_____ Date of Birth (Mon/Day/Yr):_____

Social Security Number:_____-_____-_____ Male_____ Female_____
(Social Security information is required by MN Statute 270.72 Subd. 4)

Have you ever used another legal name under which records may be filed concerning your application, including your education training or experience? _____Yes _____No

If yes, please list name(s) used:_____

Applicant's Name_____

INSTRUCTIONS: List the full name and complete address with telephone number of each employer for whom you practice as an occupational therapist or occupational therapy assistant. If the employer is a placement service or you rotate to different work locations, list the employer's name and complete address with telephone number then list the name and address with telephone number of each location where you work in the state of Minnesota for that employer. Complete an application for each work location.

Employer/Business Name:_____**Employer/ Business Telephone:** _____

Employer/Business Address:_____
Street City State Zip

Place of Employment Name:_____

Place of Employment Address:_____
Street City State Zip

Place of Employment Telephone: _____**Place of Employment Fax Number:**_____

APPLICANT AFFIRMATION: I hereby make application for a temporary license. I have completed the educational requirements for credential as described in Minnesota Statutes §148.6401 to §148.6450 including fieldwork placement. I understand that as a temporary licensee, I must practice under the supervision of a Minnesota credentialed occupational therapist. I understand that a temporary license expires six months from the date of issuance and that to continue practicing and using a protected title after the expiration of a temporary license, I must apply for and obtain either 1) a renewal of my temporary license, or 2) full licensed status as an occupational therapist or occupational therapy assistant. I understand that approval of temporary license and status as a temporary licensee creates no rights to or expectation of approval of the Minnesota Department of Health for a license as an occupational therapist or occupational therapy assistant. By signing below, I certify that I have read and will comply with the requirements of Minnesota Statutes §148.6401 to §148.6450.

_____ _____
Applicant Signature **Date**

PART II. To be completed by Supervisor

_____ _____
Name of Supervisor (Print) **Minnesota Credential Number**

INSTRUCTIONS: List the full name and complete address with telephone number of each employer for whom you practice as an occupational therapist or occupational therapy assistant. If the employer is a placement service, list the employer's name and complete address with telephone number then list the name and address with telephone number of each work location where you worked for that employer in the state of Minnesota. Complete an application for each work location

Supervisor Employer/Business Name: _____**Telephone:**_____

Supervisor Place of Employment Name:_____

Supervisor Place of Employment Address:_____
Street City State Zip

Date I started employment (Mon/Day/Yr) _____

I notified the MDH of this employment ((Mon/Day/Yr) _____

Supervisor Place of Employment Phone Number:_____**Supervisor Place of Employment Fax Number:**_____

Supervisor Place of Employment Email address:_____

I certify that I am a credentialed occupational therapist in the state of Minnesota and the supervisor of the above-named applicant who has applied for temporary license pending receipt of a qualifying score on the examination required for licensing by Minnesota Statutes §148.6401 to §148.6450. I have read Minnesota Statutes §148.6418 and will provide supervision consistent with Subd. 4. I understand that a temporary license expires six months from the date of issuance for occupational therapists and occupational therapy assistants or on the date the commissioner grants or denies licensure, whichever occurs first. Furthermore, I understand that I am the responsible supervisor for the above applicant until the Minnesota Department of Health receives my written and signed statement that I wish to cease supervision or until expiration of the temporary license.

_____ _____
Supervisor Signature **Date**

Applicant's Name_____

WAIVER & RELEASE

Under the Minnesota Government Data Practices Act, Minnesota Statutes, chapter 13, all information received as part of an active investigation is confidential data. If my application for a temporary license as an occupational therapist or occupational therapy assistant is approved, I hereby authorize the Minnesota Department of Health to notify my supervisor in the event the Department receives a complaint against me concerning an act or omission related to the provision of occupational therapy services.

By signing below, I waive any privilege afforded to me by the law relating to the disclosure of complaint information and allegations. I further release the Department, its agents or employees from liability for releasing complaint information and allegations to my supervisor. This waiver shall remain in effect until the approved temporary license expires, is revoked, or suspended, or until the temporary licensee or approved supervisor listed on this application notifies the Department, in writing, that supervision has been withdrawn.

_____
Temporary Licensee Signature

_____
Date

_____
First Name, Middle Name and Last Name (Printed)

_____
Home Address

_____
City, State, and Zip Code

I have read and understand the instructions for this application process.

_____
Temporary Licensee Signature

$50.00 license fee is required

UPON REQUEST, THIS MATERIAL WILL BE MADE AVAILABLE IN ALTERNATIVE FORMAT; FOR EXAMPLE, LARGE PRINT, BRAILLE, OR CASSETTE TAPE.