MINNESOTA MDH DEPARTMENT OF HEALTH	**Health Occupations Program** **Attn: OTA Licensing** **P.O. Box 64882** **St. Paul, MN 55164-0882** **(651) 201-3724**	**For office use only**

Application for Licensing as an Occupational Therapy Assistant

MINNESOTA GOVERNMENT DATA PRACTICE ACT NOTICE. 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 §§148.6401 to 148.6450 requirements for licensing. 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 licensing 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.

PLEASE PRINT

Do you or have you previously held a Temporary or Full Credential in the State of Minnesota as an OTA?

_____NO _____ YES If yes, Credential Number _____ If your OTA license is lapsed/expired DO NOT USE this application.

APPLICATION METHOD:(check one)_____ A. Licensing by Equivalency_____ **B.** General Licensing_____**C.** Licensing by Reciprocity

A. Equivalency – I contacted NBCOT for a verification to be sent (enter date) _____.
B. General Licensing – I contacted my school (enter date) _____. I took the test and passed (enter date)_____.
C. Reciprocity – I am using the State of _____ and I have contacted them (enter date) _____to have the laws sent.

BACKGROUND

1. Name: _____
(Last Name) (First Name) (Middle Name)

2. Home Number: (____)_____ Cell Phone Number (____)_____

3. Email Address: _____

4. Please designate with an "X" the address at which you will receive correspondence from the Department regarding your license and which will be public information: (choose **ONE**) HOME_____EMPLOYER_____

5. Home Address: _____
(P.O. BOX IS NOT ACCEPTABLE AS HOME ADDRESS)

_____
(City) (State) (Zip)

6. Male_____ Female_____ Date of Birth_____/_____/_____

   a. Social Security Number_____ This information is required by M.S. 270C.72

7. Have you ever used another legal name under which records may be filed concerning your application, including your education, training or experience? _____ No _____Yes
   If yes, please list name(s) used: _____

EDUCATIONAL BACKGROUND:

Institution/Location	Dates Attended (Mon/Yr – Mon/Yr)	Degree Received	Area of Study/Major

PROFESSIONAL BACKGROUND:

8. List the name and complete address of each employer for whom you have practiced as an occupational therapy assistant in the last six years. List your current employer first. You must list all employment dates as shown (Mon/Day/Yr). **If the employer is a placement service or you rotate to different work locations, list the employer's name, address and the name and address of each location where you worked for that employer.** Use page 7 and additional sheets if necessary.

   A. Current Employer: _____ Telephone: (_____)_____

   Address:_____ City_____ State_____ Zip_____

   Fax Number_____

   (Mon/Day/Yr- Mon/Day/Yr):_____ Number of hours worked per week:_____

   B. Employer: _____ Telephone: (_____)_____

   Address:_____ City_____ State_____ Zip_____

   Fax Number_____

   (Mon/Day/Yr- Mon/Day/Yr):_____ Number of hours worked per week:_____

   C. Employer: _____ Telephone: (_____)_____

   Address:_____ City_____ State_____ Zip_____

   Fax Number_____

   (Mon/Day/Yr- Mon/Day/Yr):_____ Number of hours worked per week:_____

   D. Employer: _____ Telephone: (_____)_____

   Address:_____ City_____ State_____ Zip_____

   Fax Number_____

   (Mon/Day/Yr- Mon/Day/Yr):_____ Number of hours worked per week:_____

9. Minnesota County of primary employment: _____

10. OTP Employment Setting: (Check all that apply.)___ Academic; ___ Clinic; ___ Community-Based Care;___ Home Care; ___ Hospital; ___ Long-Term Care Facility; ___ School System; ___ Unemployed

11. Do you hold or have you ever been issued a credential as an Occupational Therapy Assistant in this or another state or jurisdiction? _____ Yes _____No If yes, please identify the state(s) or jurisdiction, the current status (e.g. active, inactive or expired), the date issued, expiration date and any identification number(s) used in relation to your temporary permit, registration, license or other credential. Use page 7 and additional sheets if necessary.

State Type of Credential Status Original Date Issued Expiration Date ID. #'s

_____

_____

_____

_____

12. **For each state or jurisdiction in which you hold or have held a credential as an occupational therapy assistant, you must submit the Occupational Therapy Assistant Verification of Credential form (included in the instructions).** Mail the form to the state credentialing board or agency with any required fees, and request that they send the completed form directly to the Health Occupations Program of the Minnesota Department of Health. The letter(s) must have the original signature of the appropriate official. You may photocopy this form, if additional forms are necessary.

    As an alternative, you may submit a letter of verification from the state indicating your name, date of birth, credential number, date of issuance, a statement regarding investigations pending and disciplinary actions taken or pending, current status of the credential, and the method by which you qualified for the credential. The letter(s) must have original signatures. Copies and/or typed names are unacceptable.

    NOTE: Applicants who are applying for licensing by reciprocity must request that the credentialing state also provide a copy of the state statute or administrative rule which describes the state qualifications for your credential at the time your credential was issued.

    Date you requested the information:_____

13. A. Is action being taken against you or your legal authorization to practice occupational therapy in this, or another state or jurisdiction, either through revocation, suspension, restrictions, limitations, conditions, reprimand or any other means?
    (Include Stipulation and Consent Orders)
    _____Yes _____No

    B. Has action ever been taken against you or your legal authorization to practice occupational therapy in this, or another state jurisdiction, either through revocation, suspension, restrictions, limitations, conditions, reprimand or any other means?
    (Include Stipulation and Consent Orders)
    _____Yes _____No

    If yes to either question, please explain the reason for the action, action taken, and name the state, address of credentialing authority in possession of record, dates, and party or parties involved in the action. Use page 7 and additional sheets if necessary.

    _____

    _____

    _____

14. A. Is action being taken against you by the National Board for Certification in Occupational Therapy (formerly the American Occupational Therapy Certification Board) either through revocation, suspension, restrictions, limitations, condition, reprimand or any other means?
    _____Yes _____No

    B. Has action ever been taken against you by the National Board for Certification in Occupational Therapy or its predecessor the American Occupational Therapy Certification Board either through revocation, suspension, restrictions, limitations, condition, reprimand or any other means?
    _____Yes _____No

    If yes to either question, please explain the reason for the action, action taken, dates, and party or parties involved in the action. Use page 7 and additional sheets if necessary.

    _____

    _____

    _____

15. Have you ever applied for and been refused credential to practice any occupation in this or any other state?
_____Yes _____No

If yes, please explain the reason for the denial, the name of the state, address of credentialing authority in possession of record, and date of the denial. Use page 7 and additional sheets if necessary.

_____

_____

16. Have you been convicted of a felony or misdemeanor which relates to the practice of occupational therapy or which involved dishonesty? _____Yes _____No

If yes, give a statement supplying full details including the crime(s) of which you were convicted, date(s), name(s) and location of court(s) and case number(s). Use page 7 and additional sheets if necessary.

_____

_____

17. Do you have any criminal charges related to the practice of occupational therapy pending against you? _____ Yes _____No
If yes, provide a statement giving full details on page 7.

18. Have you had an order related to the practice of occupational therapy entered against you in State or Federal court; including a conciliation court judgment or disciplinary order? _____Yes _____No

If yes, give a statement supplying full details including order(s), date(s), name(s), and location of court(s) and case number(s). Use page 7 and additional sheets, if necessary.

_____

_____

19. Do you have a physical or mental condition or chemical dependency that currently impairs your ability to engage in the practice of occupational therapy with reasonable judgment or safety ? _____Yes_____No
If yes, please explain on page 7.

20. Have you ever engaged in or aided or abetted another in engaging in any of the following acts or conduct whether or not you have been formally disciplined? If the answer to any of the following is yes, please provide an explanation on page 7 and additional sheets if necessary.

	YES	NO	
A.	____	____	Submitted false or misleading information to the Commissioner.
B.	____	____	Failed to provide information within 30 days in response to a written request from the Commissioner.
C.	____	____	Performed services as an occupational therapy assistant in an incompetent manner or in a manner that falls below the community standard of care.
D.	____	____	Failed to satisfactorily perform occupational therapy services during a period of provisional licensing.
E.	____	____	Violated Minnesota Statutes §§148.6401 to 148.6450.

Applicant Name_____

	YES	NO	
F.	____	____	Failed to perform occupational therapy services with reasonable judgment, skill, or safety due to the use of alcohol or drugs within the three years prior to application.
G.	____	____	Been convicted of violating any state law, rule, or regulation which directly relates to the practice of occupational therapy.
H.	____	____	Been disciplined for conduct in the practice of an occupation by the state of Minnesota, another jurisdiction, or a national professional organization, if any of the grounds for discipline are the same or substantially equivalent to those in Minnesota Statutes §§148.6401 to 148.6450.
I.	____	____	Failed to cooperate with the Commissioner in an investigation of a complaint that alleges or implies violation of Minnesota Statutes §§148.6401 to 148.6450.
J.	____	____	Advertised in a manner that is false or misleading.
K.	____	____	Engaged in dishonest, unethical or unprofessional conduct in connection with the practice of occupational therapy that is likely to deceive, defraud, or harm the public.
L.	____	____	Demonstrated a willful or careless disregard for the health, welfare, or safety of a client
M.	____	_____	Performed medical diagnosis or provided treatment without being licensed to do so under the laws of Minnesota.
N.	____	____	Paid or promised to pay a commission or part of a fee to any person who contacts you for consultation or sends patients to you for treatment.
O.	____	____	Engaged in an incentive payment arrangement that promotes occupational therapy overutilization.
P.	____	____	Engaged in abusive or fraudulent billing practices, including violations of Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical assistance laws.
Q.	____	____	Obtained money, property, or services from a consumer through the use of undue influence, high pressure sales tactics, harassment duress, deception, or fraud.
R.	____	____	Performed services for a client who had no possibility of benefitting from the services.
S.	____	____	Failed to refer a client for medical evaluation when appropriate or when client indicated symptoms associated with diseases that could be medically or surgically treated.
T.	____	____	Engaged in conduct with a client that is sexual or may reasonably be interpreted by the client as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient.
U.	____	____	Violated a federal or state court order, including a conciliation court judgment, or a disciplinary order issued by the Commissioner, related to your occupational therapy practice.

Applicant Name_____

RECORDS WAIVER AUTHORIZATION AND RELEASE

I HEREBY AUTHORIZE THE COMMISSIONER OF THE MINNESOTA DEPARTMENT OF HEALTH or the Commissioner's designee to obtain, and authorize the person to whom this authorization is presented to release, any and all information contained in the educational, National Board for Certification in Occupational Therapy, license, registration, permit or other credentialing records, including investigative and/or disciplinary records, in this or any other state where I have practiced occupational therapy.

This authorization also allows the Commissioner or the Commissioner's designee to make summaries or photocopies of all or any portion of any records pertaining to my authority to practice occupational therapy in this or any other state. A photocopy of this authorization may be considered to be as valid as the original.

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Dated this _____ day of _____, 2_____.

_____
Signature

_____
Name (printed)

_____
Address (street address)

_____
City, State, and Zip Code

The information I have provided in this application is true and accurate to the best of my knowledge and belief. I have read and will comply with the requirements of Minnesota Statutes §§148.6401 to 148.6450.

_____ _____
(Signature) (Date)

Please return the completed and signed application, signed records waiver authorization and release, fees and documents necessary to make your application complete to:

Minnesota Department of Health
Health Occupations Program
Attn: Occupational Therapy Assistant Licensing
P.O. Box 64882
St. Paul, MN 55164-0882

Applicant Name_____

MINNESOTA DEPARTMENT OF HEALTH

Application for Licensing as an Occupational Therapy Assistant.

Please use this page to complete answers only when there is insufficient space following the questions on the preceding pages.

Question Number Answer

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Signature required only when using this page to complete answers Date

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