Washington State Department of Health
Occupational Therapy Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Employment Verification/Affidavit For Internationally Educated

Internationally educated applicants **only** must fill out this form required by **WAC 246-847-120**.

Name of facility _____ Phone Number _____

Name of direct supervisor_____ Title of direct supervisor _____

Street address_____

City _____ State _____ Zip Code _____

This section to be completed by applicant

Applicant **must** complete this affidavit for **each place of employment** during the three years immediately prior to the date of application for a Washington license. You may duplicate this form as necessary.

I certify I provided occupational therapy services at the facility named above during the time period:

The capacity in which I was employed; including job title, specific duties, and nature of clientele are listed below:

Beginning date _____ Ending date: _____

The capacity in which I was employed; including job title, specific duties, and nature of clientele are listed below:

Job title	Specific duties	Nature of clientele

I certify the information I provided above is true to the best of my knowledge. I understand if I provide any false information, my license may be denied, suspended or revoked.

Signature _____Date _____

This section to be completed by supervisor/personnel manager and returned to the above address

I certify _____
Name of applicant

Satisfactorily provided services at this facility in the capacity of an occupational therapist/occupational therapy assistant during the time period: Beginning date _____ Ending date: _____

List his/her specific duties _____

Name _____Date _____

Signature _____
Person completing this form (printed)

Title _____Phone number _____