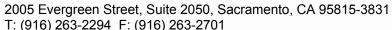
BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY . GOVERNOR EDMUND G. BROWN JR.

CALIFORNIA BOARD OF OCCUPATIONAL THERAPY





E-mail: cbot@dca.ca.gov Web: www.bot.ca.gov

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

Section I: Personal Data (Please Complete All Boxes)

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

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-Ma	ail Address
I. Current Employer		J. Supervisor First Name	K. Supervisor Last Name	
Section II: Affidav	it	1		
and know the contents that all of the inform true and correct. I application or any atta	s thereof. I declare, under lation contained herein an understand that falsification	nis application and that I have repenalty of perjury of the law devidence or other credention or misrepresentation of an grounds for denial, suspension f California.	s of the S als subm y item or	itate of California, itted herewith are response on this
Signature of Applicant		Date		
Business and Professior mandatory. Failure to prinformation provided will	ns Code section 2570.18 giver rovide any mandatory informa be used to determine qualifica	cutive officer is the person responses the Board authority to maintain tion will result in the application tion for advanced practice approvious to the provisions of the California	ain informa being rejec val. Each i	ation. All information i cted as incomplete. Th ndividual has the right t

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 – SWALLOWING ASSESSMENT, EVALUATION AND INTERVENTION:

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

# of Hours:	Course Title:
	Total Contact Hours
SWALLOWIN (Minimum of	NG ASSESSMENT, EVALUATION AND INTERVENTION TRAINING 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.

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 each course.

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

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	n(month/day/year) and
(month/day/year).	
Supervisor's Name:	
First	Last
License Type/Number:	Supervisor's Phone #:
Name and Address of Facility Where Training Occurred:	
IS OT applicant's name	competent in providing swallowing assessment,
evaluation, or intervention?	
<u> </u>	nonstrated swallowing assessment, evaluation or intervention. ed competence in swallowing assessment, evaluation or
Please identify the knowledge, sk	cills and abilities demonstrated by the OT:
By signing below, YOU certify that and that the timeframes and hours	t you were the clinical supervisor for training hours noted above listed are true and correct.
Supervisor's Signature:	Date:

Note to Supervisor:

➤ Until the Board approves this applicant, you have <u>continuing</u> 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.