Reset Form

APPLICATION FOR CERTIFICATION AS AN OCCUPATIONAL THERAPIST OR OCCUPATIONAL THERAPY ASSISTANT

State Form 43826 (R15 / 3-25)

OCCUPATIONAL THERAPY COMMITTEE
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-8800
E-mail: pla14@pla.IN.gov
www.pla.IN.gov

INSTRUCTIONS:
1. *The fee for this application is $100.00, payable to the Indiana Professional Licensing Agency, in accordance with 844 IAC 10-2-2.*
2. *If applying for a temporary permit, please include your fee of $50.00 in accordance with 844 IAC 10-2-2.*
3. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
4. *All fees are non-refundable and non-transferable.*
5. *Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.*

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.

FOR OFFICE USE ONLY				
Fee received	Date received *(month, day, year)*	Receipt number	Certification number issued	Certification issuance date *(month, day, year)*
Temporary fee received	Date received *(month, day, year)*	Receipt number	Temporary permit number issued	Temporary permit issuance date *(month, day, year)*

DO NOT WRITE ABOVE THIS LINE

BASIS FOR CERTIFICATION

Do you desire a temporary permit?	By *(check one)*:	For *(check one)*:
☐ Yes ☐ No	☐ Examination ☐ Endorsement	☐ Occupational Therapist ☐ Occupational Therapy Assistant

If you are applying by examination, what date will you be taking the examination? *(Please list date (month, day, year) of examination.)*

Have you previously filed an application for certification as an Occupational Therapist or Occupational Therapy Assistant in the state of Indiana or any other state? ☐ Yes ☐ No

If yes, date of application *(month, day, year)*	Location

Have you previously taken the certifying examination for an Occupational Therapist or Occupational Therapy Assistant? ☐ Yes ☐ No

If yes, date of examination *(month, day, year)*	Location

Have you ever failed the certifying examination for an Occupational Therapist or Occupational Therapy Assistant? ☐ Yes ☐ No

If yes, date of examination *(month, day, year)*	Location

APPLICANT INFORMATION

Name of applicant (*last, first, middle*)

Social Security number *	Date of birth (*month, day, year*)
Address of applicant (*number and street or rural route*)	City, state, and ZIP code

Telephone number (*daytime*) ( )	E-mail address *(required)*

Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: *(Please select ONLY ONE of the following.)*
☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 USC § 1641). ☐ I am authorized by the Federal government to work in the United States.

Are you the spouse of a member of the military who is assigned to a duty station in Indiana? *(Optional)* ☐ Yes ☐ No	Are you an active duty member of the military? *(Optional)* ☐ Yes ☐ No

OCCUPATIONAL THERAPIST / OCCUPATIONAL THERAPY ASSISTANT DEGREE GRANTED BY

Name of school	Location	Date of graduation *(month, day, year)*

UNDERGRADUATE AND GRADUATE TRAINING				
NAME OF SCHOOL	**LOCATION**	**FROM (*month, year*)**	**TO (*month, year*)**	**DEGREE**

LIST ALL STATES, <u>INCLUDING INDIANA</u>, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION, REGARDLESS OF STATUS.

Verification of all licenses listed must be submitted directly from the state licensing board.

STATE	TYPE OF LICENSE / CERTIFICATE	NUMBER	DATE ISSUED *(month, day, year)*	CURRENT STATUS

QUESTIONS

If your answer is "Yes" to any of the following, explain fully in a signed written statement, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit issued pursuant to this application. Do not file this application without this documentation.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☐ No
2. Have you ever been denied licensure registration or certification in any state *(including Indiana)* or country? ☐ Yes ☐ No
3. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice in a competent, ethical, and professional manner? ☐ Yes ☐ No
4. *Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,*
   (1) have you ever been arrested; ☐ Yes ☐ No
   (2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state; ☐ Yes ☐ No
   (3) have you ever been convicted of any offense, misdemeanor, or felony in any state; ☐ Yes ☐ No
   (4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or ☐ Yes ☐ No
   (5) have you ever pled *nolo contendre* to any offense, misdemeanor, or felony in any state? ☐ Yes ☐ No
5. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations? ☐ Yes ☐ No
6. Have you ever been censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? ☐ Yes ☐ No
7. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ Yes ☐ No

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency, or any of its authorized representatives in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I affirm, under penalties for perjury, that the foregoing representations are true.

Signature of applicant	Date (*month, day, year*)

AFFIRMATION OF SUPERVISION

Part of State Form 43826 (R14 / 3-21)

This page is to be completed only if applying for a temporary permit.

INSTRUCTIONS: *Applicants who are applying for a temporary permit to practice as an occupational therapist or occupational therapy assistant must have this supervision letter completed. This letter must be completed and have an original signature by the certified Indiana occupational therapist who will be providing direct supervision. Faxed copies are not acceptable.*

The supervising occupational therapist shall be reasonably available and responsible at all times for the direction and action of the person supervised when services are performed by the holder of a temporary permit. Unless the supervising occupational therapist is on the premises to provide constant supervision, the holder of a temporary permit shall meet once each working day to review all patients' treatments.

APPLICANT INFORMATION	
Name of applicant (*last, first, middle, maiden*)	Social Security number *

HOSPITAL / FACILITY INFORMATION	
Name of hospital / facility	Telephone number ( )
Address (*number and street or rural route, city, state and ZIP code*)	

TO BE COMPLETED BY SUPERVISOR

I hereby swear or affirm, under the penalties of perjury, that the applicant whose name appears above will be under my direct supervision while practicing occupational therapy. According to IC 25-23.5-5-11 (b) and 844 IAC 10-5-13, I understand that I shall be available and under all circumstances shall be absolutely responsible for the direction and the actions of the person supervised when services are performed. I also understand that the patient's care shall always be my responsibility.

Signature of supervisor		Date signed (*month, day, year*)
Printed name of supervisor		Telephone number ( )
Certification number	Date of expiration (*month, day, year*)	Date supervision is to begin (*month, day, year*)