Reset Form

APPLICATION FOR CERTIFICATION AS AN OCCUPATIONAL THERAPIST OR OCCUPATIONAL THERAPY ASSISTANT

To Practice in the State of Indiana

State Form 43826 (R13 / 9-17)
Approved by State Board of Accounts, 2017

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.

Application fee	
Date fee paid *(month, day, year)*	
Receipt number	
Certification number	
Certification issuance date *(month, day, year)*	

Temporary permit fee	
Date fee paid (*month, day, year*)	
Receipt number	
Temporary permit number	
Temporary permit issuance date *(month, day, year)*	

APPLICANT

Attach one (1) passport type quality photographs of yourself taken within the last eight (8) weeks. Please sign each photo at the bottom. Negatives and Polaroids are not acceptable.

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name *(last, first, middle, maiden)*	Social Security number *
Address *(street and number or rural route, city, state, and ZIP code)*	
Date of birth (*month, day, year*)	Place of birth *(city, state or foreign country)*
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 one of the following.)*
☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 U.S.C. § 1641).

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

BASIS FOR CERTIFICATION

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

If you are applying by examination, what date will you be taking the examination?
(Please list date 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?
(If yes, please give details as to where and when.)
☐ Yes ☐ No

Have you previously taken the certifying examination for an Occupational Therapist or Occupational Therapy Assistant?
(If yes, please list date and place.)
☐ Yes ☐ No

Have you ever failed the certifying examination for an Occupational Therapist or Occupational Therapy Assistant?
(If yes, please list date and place.)
☐ 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, **including Indiana**, in which you have been licensed to practice any regulated health occupation. 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

PLACES OF EMPLOYMENT SINCE GRADUATION

NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	DATE *(month, day, year)* (Begin)	(End)

PLACES YOU HAVE LIVED SINCE GRADUATION

GENERAL LOCATION	DATE *(month, day, year)*

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, 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.

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. Do you have any condition or impairment (including a history of alcohol or substance abuse) that currently interferes, or if left untreated may interfere, with your ability to practice in a competent 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

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

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

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 certification as an occupational therapist or occupational therapy assistant.

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 such information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application and I hereby specifically release the Agency and the Committee 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 hereby swear or affirm that I have read the above statements and agree to same.

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