

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
Health Professional Licensing Administration



Board of Occupational Therapy

VERIFICATION OF REGISTRATION

TO BE COMPLETED BY APPLICANT

To the State Board of Occupational Therapy in _____
an application for registration by endorsement has been received from:

NAME: _____

ADDRESS: _____

Identified as a graduate of _____
(School of Occupational Therapy)

_____ Licensed year _____
(Location of)

TO BE COMPLETED BY STATE BOARD OF OCCUPATIONAL THERAPY

Kindly verify the registration of the above person in your state by giving us the following information:

Registration Number _____ Date Issued _____

By Examination _____ By Waiver _____

By Reciprocity _____ By Endorsement _____

Is the applicant currently registered? _____

Has registration ever been surrendered, suspended, or revoked? _____

If yes, has it been reinstated? _____

PLEASE GIVE FULL PARTICULARS ON REVERSE SIDE OF THIS FORM

On behalf of _____ the State of _____

I certify the above statements are correct.

(SEAL)

Signature _____

State _____

Date _____