



## SECTION II: EMPLOYER CERTIFICATION OF SUPERVISION

### INSTRUCTIONS TO THE EMPLOYER AND SUPERVISOR:

1. By completing the sections below you are certifying that the permit applicant named in Section I will be employed under the supervision of a New York State licensed and currently registered occupational therapist or physician.
2. A limited permit shall expire one year from the date it was issued or will become void if the permittee fails the licensing examination.
3. **The limited permit does not authorize the treatment of patients in a home care service of any hospital, clinic or agency or in a private practice.**

Print full name of employer: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax: ( \_\_\_\_\_ ) \_\_\_\_\_ E-mail \_\_\_\_\_

### APPLICANT PRACTICE SITE INFORMATION

Site: \_\_\_\_\_

Address: \_\_\_\_\_

The above facility is a: (check one)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Public hospital                                | <input type="checkbox"/> Public health agency            | <input type="checkbox"/> Voluntary hospital |
| <input type="checkbox"/> Licensed proprietary hospital                  | <input type="checkbox"/> Licensed nursing home           |   |
| <input type="checkbox"/> Recognized public or non-public school setting | <input type="checkbox"/> Incorporated hospital or clinic |   |

Site: \_\_\_\_\_

Address: \_\_\_\_\_

The above facility is a: (check one)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Public hospital                                | <input type="checkbox"/> Public health agency            | <input type="checkbox"/> Voluntary hospital |
| <input type="checkbox"/> Licensed proprietary hospital                  | <input type="checkbox"/> Licensed nursing home           |   |
| <input type="checkbox"/> Recognized public or non-public school setting | <input type="checkbox"/> Incorporated hospital or clinic |   |

### ATTESTATION

In accordance with the instructions above, I declare that the statements made in Section II are true, complete and correct. Any false or misleading information in, or in connection with, this certification may be cause for denial of permit and licensure and may result in criminal prosecution.

Supervisor's name: \_\_\_\_\_

Are you employed at the same place of employment as the applicant?  Yes  No

If yes, how many hours per week are you employed there? \_\_\_\_\_

Supervisor's signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

**Credentials:**  Occupational Therapist  Physician New York State license number: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax: ( \_\_\_\_\_ ) \_\_\_\_\_

E-mail \_\_\_\_\_

**RETURN DIRECTLY TO:** \_\_\_\_\_

New York State Education Department, Office of the Professions, Division of Professional Licensing Services,  
P.O. Box 22063, Albany, NY 12201