Occupational Therapy Form 5

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Application for Limited Permit

Department Use Only

Permit Number

Date Issued

Date Expires

Initials

Applicant Instructions

1. **You may file an application for a limited permit to practice pending receipt of the license with or after submitting an Application for Licensure (Form 1 and fee) as an occupational therapist or occupational therapy assistant in New York State.** A limited permit authorizes practice as an occupational therapist or occupational therapy assistant under the supervision of a New York State licensed, currently registered occupational therapist or physician with the endorsement of the employer. Be sure that your prospective employer and supervisor fully complete Section II, Employer Certification of Supervision.
2. Complete Section I in ink. Be sure to sign and date item 9. **Note:** Once limited permits are issued, the starting date may not be adjusted. You should be certain you are ready to begin practice when you apply for the limited permit.
3. Submit this application and the $70 limited permit fee to the Office of the Professions at the address at the end of the form. If you have not yet filed an Application for Licensure (Form 1) with the appropriate fee, you **must submit them with this form.** You may not begin practice until your limited permit is issued. A limited permit is valid for one year and may be renewed for an additional year upon submission of an explanation satisfactory to the Department as to why you failed to become licensed within the year of the original permit.
4. If you change employment or supervisor after a permit is issued, you must obtain a new permit and, with each prospective employer/supervisor, complete a new Form 5 and return it to the Office of the Professions. A new fee is not required for a permit issued as a result of a change in employment.

Section I: Applicant Information

1 **Check what you are applying for:**

☐ **Occupational Therapist**	**63**	**$70**	**PR**
☐ **Occupational Therapy Assistant**	**64**	**$70**	**PR**

2 **Social Security Number**
(Leave this blank if you do not have a U.S. Social Security Number)

3 **Birth Date** Month Day Year

4 **Print Name**

Last

First

Middle

5 **Mailing Address** (You must notify the Department promptly of any address or name changes.)

Line 1

Line 2

Line 3

City

State Zip Code

Country/ Province

6 **Telephone/E-Mail Address**

Daytime Phone

Area Code Phone Number

E-Mail Address (Please print clearly)

7 **I Am Applying For:**

- ☐ Original Permit
- ☐ Renewal of Original Permit (attach explanation)
- ☐ Change in:
  - ☐ Employer
  - ☐ Supervisor
- ☐ Additional:
  - ☐ Employer
  - ☐ Supervisor

8 Name as it appears on diploma if different from above: _____

9 **Attestation**

Notice to Applicants Regarding Limited Permit Authorizing Practice as an Occupational Therapist or Occupational Therapy Assistant: The law authorizes a permittee to practice under the supervision of a licensed and currently registered occupational therapist or physician in a **public, voluntary, or proprietary hospital or health care agency, or in a preschool or elementary school as a related service for a handicapped child.**

I declare and affirm that the statements made in the foregoing application are true, complete and correct. Any false or misleading information in, or in connection with, my application may be cause for denial of permit and licensure and may result in criminal prosecution.

_____ _____ / _____ / _____
Applicant's signature mo. day yr.

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.

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)

- ☐ Public hospital
- ☐ Licensed proprietary hospital
- ☐ Recognized public or non-public school setting
- ☐ Public health agency
- ☐ Licensed nursing home
- ☐ Incorporated hospital or clinic
- ☐ Voluntary hospital

Site: _____

Address: _____

The above facility is a: (check one)

- ☐ Public hospital
- ☐ Licensed proprietary hospital
- ☐ Recognized public or non-public school setting
- ☐ Public health agency
- ☐ Licensed nursing home
- ☐ Incorporated hospital or clinic
- ☐ Voluntary hospital

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 loss of 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