

STATE BOARD OF OCCUPATIONAL THERAPY EDUCATION & LICENSURE

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OCCUPATIONAL THERAPY CONTINUING EDUCATION PROVIDER APPLICATION

“Pre-approved” status is granted to the following providers, from which this application is **NOT** required. All other providers must submit this application. Assure that certificates of completion are issued as per item “b” below.

1. A national, international or state level occupational therapy association.
2. The American Occupational Therapy Association’s Approved Provider Program.
3. American Society of Hand Therapists.
4. Association for Driver Rehabilitation Specialists.
5. Department of Education.
6. An accredited college or university or post-secondary vocational technical school or institution.
7. Federal or state government programs related to health care.
8. A provider approved by another health licensing board within the Bureau of Professional and Occupational Affairs or another State licensure board.
9. National and State professional health care organizations.
10. National and State professional education organizations.
11. National Alliance for the Mentally Ill.
12. Case Management Society of America.

INFORMATION:

- Continuing education must be designed to advance the licensee’s professional knowledge and skills related to the practice of occupational therapy as defined in Section 2 of Act 140 of 1982. **No credit will be given for courses in administrative services or office practices.**
- One (1) contact hour equals 50-60 minutes of actual instruction. Breaks and lunch cannot be counted as instruction time.

THE FOLLOWING DOCUMENTS MUST BE SUBMITTED WITH THIS APPLICATION TO THE ABOVE ADDRESS:

- a. A course outline AND detailed course description, with specific learning objectives, including hourly schedule.
- b. A sample of the **Certificates of Completion** to be issued to each attendee. The sample must contain the name of the provider, title of course, date of course, and spaces for inclusion of the name of the attendee, the number of hours completed, signature of person verifying completion and a space entitled “PA Board Approval Number: _____” (This notation is not required of the providers noted above). The Board approval number will be sent by the Board with the approval notification.
- c. FEE: \$40.00 check or money order payable to “Commonwealth of PA”. The fee is not refundable. A processing fee will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment
- d. Must be submitted at least 60 days prior to the date of the course(s) but no later than 90 days before the end of the biennial renewal period.
- e. Provider approval is valid for the 2 year biennial period, from the date the course is first given for credit, provided the faculty and learning objectives are unchanged. All Pennsylvania provider approvals expire June 30 of each odd numbered year.
- f. If you wish to continue as a provider, the provider approval must be renewed each biennium.
- g. This form must be printed or typed only.

IT IS YOUR RESPONSIBILITY TO MAINTAIN A COPY OF THIS APPLICATION AND ALL DOCUMENTS SUBMITTED TO THE BOARD OR RECEIVED FROM THE BOARD FOR YOUR FUTURE REFERENCE.

1. _____
Name of Provider (agency, organization, institution, center)

2. _____
Address City State Zip

3. (_____) _____
Telephone number

4. _____
Email address

5. Provide the following:
Statement of purpose of provider: _____

6. Principal contact person:

Name Telephone number

Address City State Zip

7. _____
Name of course

Date of course

Name(s) of Instructor(s)

Course is administered via (check applicable)--
 In-person instructor /speaker
 Correspondence (written material)
 Individual study (includes online)
Number of hours requested _____

IF ADDITIONAL COURSES ARE BEING INCLUDED, PLEASE PROVIDE DOCUMENTATION FOR EACH COURSE ON A SEPARATE PIECE OF PAPER.

8. Describe the criteria for selecting and evaluating faculty instructor, subject matter and instructional materials.

9. Describe the mechanism for measuring the quality of the program being offered. _____

10. Describe the criteria for evaluating each program to determine its effectiveness. _____

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 Pa.C.S. Section 4911.

Signature of provider _____ Date _____

OFFICIAL BOARD USE ONLY
Provider Number _____
Board member reviewing _____
Date approved _____
Date disapproved and reason _____