Registration Application Form
Newfoundland and Labrador Occupational Therapy Board
P.O. Box 23076, St. John's, NL A1B 4J9
Ph: 709-697-4920, Fax: 709-383-0135
www.nlotb.ca

General Information		
Legal First Name	Legal Last name	Middle Name
Previous Legal Name (if name changed since graduation)		License # (if previously licensed with NLOTB)
Mailing Address (#, Street Name, City/Town, Postal Code)		Home Telephone #
Home Email Address	Work Email Address	Work Telephone #
CAOT Number	Birth Year	

Registration Category

☐Full License

☐Provisional License (I have not yet passed the CAOT exam)

☐Temporary License (I am registered/licensed in another jurisdiction and require a time limited registration in NL)

☐Other

Language		
First Language:	Language of OT Instruction:	Languages in which you can personally and competently provide professional services:

Legal Authorization to Work in Canada

□ I am a Canadian citizen
□ I have a permanent resident status or am a landed immigrant
□ I have a valid work permit issued by Citizenship & Immigration Canada which allows me to work as an occupational therapist in Canada. Work permit expiry date: _____
□ I do not yet meet this requirement

Level of Basic Education in Occupational Therapy				
Degree Code:	University	Prov/State	Country	Year of Graduation
Level of Post-Basic Education in Occupational Therapy				
Degree Code:	University	Prov/State	Country	Year of Graduation
Degree Code:	University	Prov/State	Country	Year of Graduation
Degree Code:	University	Prov/State	Country	Year of Graduation

Degree Codes: 10 diploma 20 Baccalaureate 32 Post-Entry Masters 50 Doctorate

Education Other than Occupational Therapy (please indicate all of your education experience other than OT)					
Degree Code:	University	Field of study code:	Prov/State	Country	Year of Graduation
Degree Code:	University	Field of study code:	Prov/State	Country	Year of Graduation
Degree Code:	University	Field of study code:	Prov/State	Country	Year of Graduation

Degree Codes: 10 diploma 20 Baccalaureate 30 Professional Masters 40 Research Masters 50 Doctorate

Field of study Codes:

010 General Rehabilitation Science
020 Health Administration/Management
030 Public Administration
040 Public Health
050 Kinesiology and Exercise Sciences
060 Gerontology
070 Psychology
080 Health Professionals and Related Clinical Sciences
090Biological, Biomedical and Physical Sciences
100 Social Sciences, Art and Humanities
110 Education
120 Law
130 Business Management, Marketing and Related
140 Other Field of Study

National Occupational Therapy Certification Exam (CAOT)

Please select the category that applies to you:

□ I have successfully completed the Canadian Association of Occupational Therapists (CAOT) National Certification Exam. Date: _____

□ I am registered to take the CAOT National Certification Exam at a future date. Date of exam: _____

□ I am applying under the Labor Mobility Support Agreement.

Currency Hours

Please check the box that applies to you:

□ I have completed at least 600 hours of service within the scope of practice of occupational therapy in the 3 years immediately prior to the date of this application.

□ I graduated within the last 18 months.

□ I have completed a Board approved re-entry program within the last 18 months.

□ I am applying under the Labour Mobility Support Agreement (LMSA) and am currently registered/licensed in _____ (Canadian province).

□ I currently do NOT meet any of the above currency requirements and require a review.

Occupational Therapy Employment History over the past 10 years

Employer Name and Address	Period of Employment (start and end date)	Average Hours/week	Total hours/year (does not include any type of leave)

Conduct

If you answer "yes" to any of these questions, please provide additional information.

Yes ☐ No ☐	a) Have you ever been refused registration by an occupational therapy regulatory organization that has not previously been reported to the Board?
Yes ☐ No ☐	b) Have you had a finding of, or are you currently facing a proceeding for, professional misconduct, incompetency, incapacity or a similar issue as an OT in another jurisdiction, that has not been previously reported to the Board?
Yes ☐ No ☐	c) Have you had a finding of, or are you currently facing a proceeding for professional misconduct, incompetency, incapacity or a similar issue in another profession other than OT in NL or elsewhere, that has not been previously reported to the Board?
Yes ☐ No ☐	d) Have you been found guilty of an offence related to the practice of occupational therapy that has not been previously reported to the Board?
Yes ☐ No ☐	e) Have you been found guilty of any offense that has not been previously reported to the Board?
Yes ☐ No ☐	f) Is there anything else in your previous conduct that would afford reasonable grounds for the belief that you lack the knowledge, skill, judgment to practice safely and ethically?
Yes ☐ No ☐	g) Are you currently registered/licensed to practice in a profession other than OT in NL or elsewhere? If yes, you must provide all details required below. Provide the information below for EACH registration or license. Regulatory Body _____ Province/State/Country _____ License/Registration # _____ Expiry Date _____ _____ _____ _____ _____

Professional Registration in OT

A) Are you or have you been registered/licensed to practice OT in other provinces/states/countries/jurisdictions? Yes ☐ No ☐

If yes, provide the information below for EACH registration or license. A Regulatory History Form is required from all jurisdictions for the past 10 years.

Regulatory Body	Province/State/Country	License/Registration #	Expiry Date

Professional Liability Insurance

Yes □ No □ Do you have professional Liability Insurance?

Please provide verification of professional malpractice insurance with your application.

Employment Profile: If you do not have an offer of employment please skip this section

Practice Site 1: *Primary Employment*

Employer Name	Postal Code
Address	Country
City	Telephone
Province	Fax
Start date or return to work date:	Postal Code reflects site of practice: Yes □ No □

Employment Category:

□ Permanent (indeterminate duration of employment and guaranteed or fixed hours per week)
□ Temporary (fixed duration of employment, based on a defined start and end date)
□ Casual (on an as-needed basis)
□ Self-Employed (a person who operates his or her own economic enterprise in OT)

Employment Status:

□ Full time (your usual hour of practice are 30 hrs or more per wk or this is your official work status)
_____ Approximate number of hours per week
□ Part time (your usual hours of practice are less than 30 hrs per wk or this is your official work status)
_____ Approximate number of hours per week
□ Casual (your official status with your employer is on an as needed basis)
_____ Approximate number of hours per week

Primary Role:

□ Administrator □ Manager □ Professional Leader/Coordinator □ Direct Service Provider □ Educator □ Researcher
□ Other

Primary Practice Setting: *(Choose one only)*

□ General Hospital
□ Mental Health Hospital/Facility
□ Rehabilitation Hospital/Facility
□ Community Health Center
□ Assisted Living Residence
□ School or School Board
□ Post-Secondary Education Institution
□ Residential Care Facility
□ Visiting Agency/Business
□ Association/Government/Regulatory Organization/Non-Government Organization e.g. Cancer Society
□ Group Professional Practice/Business
□ Industry/Manufacturing/Commercial
□ Solo Professional Practice/Business
□ Other

Area of Practice: *(Choose one only)*

□ Mental Health
□ Neurological System
□ Musculoskeletal System
□ Cardiovascular/Respiratory
□ Digestive/Metabolic/ Endocrine Systems
□ General Physical Health;
□ Client Service Management
□ Vocational Rehabilitation
□ Service Administration
□ Palliative Care;
□ Medical/Legal Related Client Service Management
□ Teaching
□ Research
□ Health Promotion and Wellness
□ Other Areas of Direct Service
□ Other Areas of Practice

Client Age Range: *(Choose one only)*

□ Preschool (0-4) □ School Age (5-17) □ Mixed Pediatrics (0-17) □ Adults (18-64) □ Seniors (65+) □Mixed Adults (18-65+)
□ All ages

Funding Source

□ Public/Government □ Private Sector/Individual Client(s) □ Public/Private mix □ Other Funding Source

Usual Weekly Hours of Work in this Practice Setting: _____

Practice Site 2: *Secondary Employment*	
Employer Name	Postal Code
Address	Country
City	Telephone
Province	Fax
Start date or return to work date:	Postal Code reflects site of practice: Yes □ No □

Employment Category:

□ Permanent (indeterminate duration of employment and guaranteed or fixed hours per week)
□ Temporary (fixed duration of employment, based on a defined start and end date)
□ Casual (on an as-needed basis)
□ Self-Employed (a person who operates his or her own economic enterprise in OT)

Employment Status:

□ Full time (your usual hour of practice are 30 hrs or more per wk or this is your official work status)
_____ Approximate number of hours per week
□ Part time (your usual hours of practice are less than 30 hrs per wk or this is your official work status)
_____ Approximate number of hours per week
□ Casual (your official status with your employer is on an as needed basis)
_____ Approximate number of hours per week

Primary Role:

□ Administrator □ Manager □ Professional Leader/Coordinator □ Direct Service Provider □ Educator □ Researcher
□ Other

Primary Practice Setting: *(Choose one only)*

□ General Hospital
□ Mental Health Hospital/Facility
□ Rehabilitation Hospital/Facility
□ Community Health Center
□ Assisted Living Residence
□ School or School Board
□ Post-Secondary Education Institution
□ Residential Care Facility
□ Visiting Agency/Business
□ Association/Government/Regulatory Organization/Non-Government Organization e.g. Cancer Society
□ Group Professional Practice/Business
□ Industry/Manufacturing/Commercial
□ Solo Professional Practice/Business
□ Other

Area of Practice: *(Choose one only)*

□ Mental Health
□ Digestive/Metabolic/ Endocrine Systems
□ Teaching
□ Other Areas of Direct Service
□ Neurological System
□ General Physical Health;
□ Client Service Management
□ Research
□ Other Areas of Practice
□ Musculoskeletal System
□ Vocational Rehabilitation
□ Service Administration
□ Health Promotion and Wellness
□ Cardiovascular/Respiratory
□ Palliative Care;
□ Medical/Legal Related Client Service Management

Client Age Range: *(Choose one only)*

□ Preschool (0-4) □ School Age (5-17) □ Mixed Pediatrics (0-17) □ Adults (18-64) □ Seniors (65+) □Mixed Adults (18-65+)
□ All ages

Funding Source

□ Public/Government □ Private Sector/Individual Client(s) □ Public/Private mix □ Other Funding Source

Usual Weekly Hours of Work in this Practice Setting: _____

Practice Site 3: *Tertiary Employment*	
Employer Name	Postal Code
Address	Country
City	Telephone
Province	Fax
Start date or return to work date:	Postal Code reflects site of practice: Yes □ No □

Employment Category:

□ Permanent (indeterminate duration of employment and guaranteed or fixed hours per week)
□ Temporary (fixed duration of employment, based on a defined start and end date)
□ Casual (on an as-needed basis)
□ Self-Employed (a person who operates his or her own economic enterprise in OT)

Employment Status:

□ Full time (your usual hour of practice are 30 hrs or more per wk or this is your official work status)
_____ Approximate number of hours per week
□ Part time (your usual hours of practice are less than 30 hrs per wk or this is your official work status)
_____ Approximate number of hours per week
□ Casual (your official status with your employer is on an as needed basis)
_____ Approximate number of hours per week

Primary Role:

□ Administrator □ Manager □ Professional Leader/Coordinator □ Direct Service Provider □ Educator □ Researcher
□ Other

Primary Practice Setting: *(Choose one only)*

□ General Hospital
□ Assisted Living Residence
□ Visiting Agency/Business
□ Mental Health Hospital/Facility
□ School or School Board
□ Association/Government/Regulatory Organization/Non-Government Organization e.g. Cancer Society
□ Rehabilitation Hospital/Facility
□ Post-Secondary Education Institution
□ Group Professional Practice/Business
□ Solo Professional Practice/Business
□ Community Health Center
□ Residential Care Facility
□ Industry/Manufacturing/Commercial
□ Other

Area of Practice: *(Choose one only)*

□ Mental Health
□ Digestive/Metabolic/ Endocrine Systems
□ Teaching
□ Other Areas of Direct Service
□ Neurological System
□ General Physical Health;
□ Client Service Management
□ Research
□ Other Areas of Practice
□ Musculoskeletal System
□ Vocational Rehabilitation
□ Service Administration
□ Health Promotion and Wellness
□ Cardiovascular/Respiratory
□ Palliative Care;
□ Medical/Legal Related Client Service Management

Client Age Range: *(Choose one only)*

□ Preschool (0-4) □ School Age (5-17) □ Mixed Pediatrics (0-17) □ Adults (18-64) □ Seniors (65+) □Mixed Adults (18-65+)
□ All ages

Funding Source

□ Public/Government □ Private Sector/Individual Client(s) □ Public/Private mix □ Other Funding Source

Usual Weekly Hours of Work in this Practice Setting: _____

Declaration and Signature

I, _____ (print your name) hereby authorize the Newfoundland and Labrador Occupational Therapy Board (NLOTB) to obtain information from other regulatory bodies, educational institutions, present and former employers, and any other sources for the purposes related to my registration and qualification. A photocopy of my signature on this page is my sufficient and irrevocable authority for these persons or entities to release this information to NLOTB. **Initial _____**

I am aware that the NLOTB is required to maintain a public register. My name, license # and employer information may be provided upon request**. Initial _____**

I agree to abide by the Occupational Therapists Act, Regulations, By-laws, Standards of Practice, Personal Health Information Act and relevant guidelines. **Initial ____**

I, hereby certify that the statements made by me on this application are complete and correct to the best of my knowledge and belief. I understand that the Board reserves the right to verify any information I provide. I understand that a false or misleading statement may disqualify me from registration or may be cause for revocation of registration. **Initial _____**

Applicant Signature _____ Date: _____

Witness Signature _____ Date: _____

Fees/Payment:			
			Indicate options chosen
NLOTB Fees	1 year license (March 1, 2017 to February 28, 2018)	$350.00	
	8 month license (July 1, 2017 to February 28, 2018)	$234.00	
	4 month license (November 1, 2017 to February 28, 2018)	$117.00	
	LMSA (Labor Mobility Support Agreement) Fee	$40.00	
	Non-Sufficient Funds (NSF) Fee	$40.00	
NLAOT Fees (membership with the NLAOT (NL Association of OT's) is a licensing requirement. Fees are paid in conjunction with Board license fee)	Full time (800+ hours)	$115.00	
	Part time (800 or less working hours/year)	$75.00	
			Total: $_____
Payment Options	□ Cheque/Money Order/Bank draft (enclosed). □ Electronic payment: see website for details (please enclose payment verification)		

Additional Documentation	
1. Completed NLOTB Registration Form (signed, dated and witnessed)	
2. Verification of Occupational Therapy Education.	
3. Verification of successful completion of the CAOT exam or Statement of Candidacy indicating eligibility to write the exam in addition to verification that you are registered to write the exam at the next available sitting.	
4. Verification of professional liability insurance.	
5. Verification of membership with Canadian Association of Occupational Therapists CAOT.	
6. Applicable fee	
7. Regulatory History Forms from all jurisdictions where your were previously/presently registered in the past 10 years.	
8. Mentorship Agreement Form (if applying for a provisional licensees). Form available on website.	
9. Documentation of English fluency (IEOT's)	
10. Labour Mobility Support Agreement (LMSA) Confirmation Form sent directly to NLOTB from other licensing jurisdiction if applicable.	

Return completed registration packages to:

Newfoundland and Labrador Occupational Board
PO Box 23076, RPO Churchill Square
St. John's, NL A1B 4J9

Fax: 1-709-383-0135
Phone: 709-687-4783
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