



Rick Scott  
Governor

H. Frank Farmer, Jr., M.D., Ph.D.  
State Surgeon General

**LICENSE VERIFICATION FORM**

**PART I: TO BE COMPLETED BY APPLICANT**

*Complete this part and submit a copy to each state where you hold or have ever held a license to practice occupational therapy, making copies of this form as necessary.*

APPLICANT NAME \_\_\_\_\_ SS# \_\_\_\_\_

ADDRESS \_\_\_\_\_

LICENSE NUMBER \_\_\_\_\_ STATE OF \_\_\_\_\_

*I hereby authorize release of any information regarding my licensure status to the Florida Board of Occupational Therapy Practice.*

APPLICANT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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**PART II: TO BE COMPLETED BY AN OFFICIAL OF STATE LICENSURE BOARD**

*Please complete this part and return this form to the address listed below.*

APPLICANT NAME: \_\_\_\_\_ STATE OF: \_\_\_\_\_

LICENSE NUMBER: \_\_\_\_\_ ISSUE DATE: \_\_\_\_\_

LICENSE BASED ON: STATE EXAM \_\_\_\_\_ NATIONAL EXAM \_\_\_\_\_  
RECIPROCITY WITH \_\_\_\_\_ ENDORSEMENT \_\_\_\_\_

IS LICENSE IN GOOD STANDING? \_\_\_\_\_

HAS THE LICENSE EVER BEEN REVOKED OR SUSPENDED? \_\_\_\_\_

IS THERE ANY DEROGATORY INFORMATION? \_\_\_\_\_

REMARKS: \_\_\_\_\_

Signature of Official \_\_\_\_\_ VERIFIED BY: \_\_\_\_\_

**BOARD SEAL** \_\_\_\_\_ Name \_\_\_\_\_

DATE: \_\_\_\_\_ Title \_\_\_\_\_