



REQUEST FOR DUPLICATE LICENSE / PERMIT

Type of license being requested:

OCCUPATIONAL THERAPIST

- POCKET LICENSE
WALL CERTIFICATE
LIMITED PERMIT

OCCUPATIONAL THERAPY ASSISTANT

- POCKET LICENSE
WALL CERTIFICATE
LIMITED PERMIT

License/Permit was: [] Lost [] Stolen [] Destroyed*
[] Other*: _____

(*Must attach license that is being replaced.)

PLEASE PRINT:

Name _____ OT/OTA # _____
Please circle one

Address _____
Street and Number

City, State, Zip Code _____

Contact Telephone Number (____) _____

Email address (optional) _____

Sign and submit this form along with a check or money order in the amount of \$15.00, per item requested, to the California Board of Occupational Therapy at 2005 Evergreen Street, Suite 2250, Sacramento, California 95815.

** Please note that this form does not constitute an address change

I certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in the foregoing request, including all supplementary statements.

SIGNATURE

DATE

Table with 4 columns: Cashier No, Amount, Date Keyed, R/C Date. Header: FOR OFFICE USE ONLY