BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
DEPARTMENT OF CONSUMER AFFAIRS • CALIFORNIA BOARD OF OCCUPATIONAL THERAPY
1610 Arden Way Suite 121, Sacramento, CA 95815
P (916) 263-2294 F (916) 567-9534 E cbot@dca.ca.gov W www.bot.ca.gov

APPLICATION TO PROVIDE ADVANCED PRACTICE POST- PROFESSIONAL EDUCATION

Instructions: Submit a complete application for each course. Applications that are not completed thoroughly will be returned. Include a copy of the proposed flyer or brochure and a sample certificate to California Board of Occupational Therapy, 1610 Arden Way, Suite 121, Sacramento, CA 95815. Please refer to Title 16, California Code of Regulations section 4154 in completing this application. Processing time is 6-8 weeks.

Indicate the advanced practice area for which you will be offering post-professional education:
☐ Hand Therapy ☐ Physical Agent Modalities
☐ Swallowing Assessment, Evaluation and Intervention

SECTION I. PERSONAL INFORMATION (Please Type or Print)

1. PROVIDER NAME

2. Mailing Address (Street, City, State, Zip Code)

3. Organization Type (select one)
☐ Association ☐ Government Agency
☐ Partnership ☐ Licensed Health Facility
☐ Corporation ☐ University, College or School
☐ Individual (SSN required)

FEIN/SSN number _____

4. California Department of Consumer Affairs Licenses/Certificates/Registrations (list only those held by the provider)

Type _____ Number _____ Expiration Date _____

Type _____ Number _____ Expiration Date _____

5. Contact Person

6. Telephone Number
( )

SECTION II. COURSE INFORMATION

Use additional sheets if necessary. This section must be completed in its entirety.

1. COURSE TITLE:

2. DATE(S) OFFERED/LOCATION:

3. Statement as to the relevance of the course to the area of advanced practice:

4. Indicate the number of minutes that each of the below listed subject matter requirements are covered in the course.

HAND THERAPY:

_____ Anatomy of the upper extremity and how it is altered by pathology.

_____ Histology as it relates to tissue healing and the effects of immobilization and mobilization on connective tissue.

_____ Muscle, sensory, vascular, and connective tissue physiology.

_____ Kinesiology of the upper extremity, such as biomechanical principles of pulleys, intrinsic and extrinsicmuscle function, internal forces of muscles, and the effects of external forces.

_____ The effects of temperature and electrical currents on nerve and connective tissue.

_____ Surgical procedures of the upper extremity and their postoperative course.

PHYSICAL AGENT MODALITIES:

_____ Anatomy and physiology of muscle, sensory, vascular, and connective tissue in response to the application of physical agent modalities.

_____ Principles of chemistry and physics related to the selected modality.

_____ Physiological, neurophysiological, and electrophysiological changes that occur as a result of the application of a modality.

_____ Guidelines for the preparation of the patient, including education about the process and possible outcomes of treatment.

_____ Safety rules and precautions related to the selected modality.

_____ Methods for documenting immediate and long-term effects of treatment.

_____ Characteristics of the equipment, including safe operation, adjustment, indications of malfunction, and care.

SWALLOWING ASSESSMENT, EVALUATION & INTERVENTION:

_____ Anatomy, physiology and neurophysiology of the head and neck with focus on the structure and function of the aerodigestive tract.

_____ The effect of pathology on the structures and functions of the aerodigestive tract including medical interventions and nutritional intake methods used with patients with swallowing problems.

_____ Interventions used to improve pharyngeal swallowing function.

5. Description of the content. Include course syllabus, goals and objectives.
6. Type of Offering (e.g. seminar, conference, in-service, web-based, etc.):
7. Number of contact hours requested:
8a. Describe the provider's background, history, and experience: (You may submit a prospectus/resume in lieu of completing this section.): b. List of similar courses previously offered by provider:

SECTION III. INSTRUCTOR INFORMATION Use additional sheets if necessary. You may submit a prospectus, resume or curriculum vitae in lieu of completing this section. However, it must contain all of the information requested below.

NOTE: If course has more than one instructor, a separate form is needed for each instructor.

1. Name:	2a. Type of License/Certificate/Registration: _____ 2b. License/Certificate/Registration Number: _____ 2c. Date Issued and Date Expires: _____

3. Education				
College/University	Major	Degree	Area of Preparation	Year Degree Granted

4. Experience (most recent first)			
Agency	Position	Scope of Practice	From Mo/Yr To Mo/Yr

5. Teaching Experience			
Title of Course	Description	Location	From Mo/Yr To Mo/Yr

SECTION IV. AFFIDAVIT.

I hereby declare under penalty of perjury under the laws of the State of California that all of the information contained herein and evidence or other credentials submitted herewith are true and correct. I understand that falsification or misrepresentation of any item or response on this application or any attachment hereto, is sufficient grounds for denial, suspension or revocation of a license to practice as an occupational therapist in the State of California.

_____ _____

Provider Signature Date

Information Collection and Access – The Board's Executive Officer is the person responsible for information maintenance. Business and Professions Code section 2570.18 gives the Board authority to maintain information. All information is mandatory. Failure to provide any mandatory information will result in the application being rejected as incomplete. The information provided will be used to determine qualification to provide advanced practice post-professional education. Each provider has the right to review its file maintained by the agency, subject to the provisions of the California Public Records Act.