



APPLICATION FOR ADVANCED PRACTICE APPROVAL – PHYSICAL AGENT MODALITIES

(Please read the *Information and Instruction Sheet* before completing the application.
 Print clearly or type all information.)

Section I: Personal Data (Please Complete All Boxes)

A. Last Name		B. First Name		C. Middle Name	
D. Residence Address (Street No., Apt No.)		City	State	Zip Code	
E. OT License No.	F. Home Telephone No. ()	G. Business Telephone No. ()	H. E-Mail Address		
I. Current Employer		J. Supervisor First Name		K. Supervisor Last Name	

Section II: Affidavit

I hereby declare that I am the person named in this application and that I have read the complete application and know the contents thereof. **I declare, under penalty of perjury of 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.

 Signature of Applicant

 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 for advanced practice approval. Each individual has the right to review his or her file maintained by the agency subject to the provisions of the California Public Records Act.

Approval in an advanced practice area demonstrates entry-level competency in the area approved. Approval does not represent expertise in this area and should not be misrepresented as such. Pursuant to Title 16, California Code of Regulations, Section 4170(f)(1) of the Ethical Standards of Practice, occupational therapists are required to accurately represent their credentials, qualifications, education, experience, training, and competency. Further, Section 4170(d) states that occupational therapists shall perform services only when they are qualified by education, training, and experience to do so.

Section IV: Post-Professional Education (Copy this form and use a separate form for each course submitted.)

Name of Course: _____

Number of Contact Hours: _____

Name of Course Provider: _____

Date Completed: _____

(Course(s) must have been taken within the 5 years immediately preceding your application for approval. A Copy of Certificate of Completion must be attached for each course.)

Required content areas – Please indicate the areas covered by the above-named course:

- 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.

A Copy of Certificate of Completion must be attached for each course.

Section V: Post-Professional Training (Copy this form and use a separate form for each training and/or affiliation.)

NOTE TO SUPERVISOR: You are being asked to provide information for an OT seeking approval in physical agent modalities. Please complete this form and return it to the OT so that it can be included in his/her application packet.

This training represents _____ hours of experience in **physical agent modalities** acquired between _____ (month/day/year) and _____ (month/day/year).

Supervisor's Name: _____
First Last

License Type/Number: _____ Supervisor's Phone #: _____
e.g., OT, SLP, MD

Name and Address of Facility
Where Training Occurred: _____

Is _____ competent in providing physical agent modalities?
OT applicant's name

- YES, competence has been demonstrated Physical Agent Modalities.
- NO, the OT has not demonstrated competence in Physical Agent Modalities.

Please identify the knowledge, skills and abilities demonstrated by the OT:

By signing below, YOU certify that you were the clinical supervisor for training hours noted above and that the timeframes and hours listed are true and correct.

Supervisor's Signature: _____ Date: _____

Note to Supervisor:

- Until the Board approves this applicant, you have continuing supervisory responsibility *even if the "training" period has ended*, IF the OT is providing Physical Agent Modalities, and you are both employed at the location named above.