MD BOARD OF OCCUPATIONAL THERAPY PRACTICE

Spring Grove Hospital Center • 55 Wade Avenue • Baltimore, MD 21228
Phone: 410-402-8560 · Website: www.mdotboard.org

MORAL CHARACTER ENDORSEMENT FORM

The Maryland State Board of Occupational Therapy Practice is gathering information to determine whether the applicant for licensure to practice occupational therapy in Maryland can be anticipated to do so ethically. **Persons who complete this form must have observed the applicant's clinical skills, and not be related to the applicant.**

Name of Applicant: ____________________________________ Social Security Number: _____-____-_____

Address: ____

City/State/Zip: ____ Phone (_____) _______________________

License Type You Are Applying For:
- Occupational Therapist □
- Occupational Therapy Assistant □
- Temporary Occupational Therapist □
- Temporary Occupational Therapy Assistant □

To the best of your knowledge, has the applicant:

1. Provided appropriate services to clients without discrimination based on age, race, creed, national origin, sex, sexual orientation, handicap, or religious affiliation? 1. □ YES □ NO

2. Shown respect for clients' rights, including the right to refuse treatment? 2. □ YES □ NO

3. Avoided cruel, inhumane, or degrading practices in the treatment of clients? 3. □ YES □ NO

4. Provided the highest quality services to clients? 4. □ YES □ NO

5. Placed the needs of the client above personal gains, financial or otherwise? 5. □ YES □ NO

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1-800-735-2258

6. Appropriately represented his or her skills? 6. □ YES □ NO

7. Continued with any procedure which appeared to be harmful to the client? 7. □ YES □ NO

8. Practiced occupational therapy without an appropriate license? 8. □ YES □ NO

9. Used any form of communication containing a false, fraudulent, misleading, or deceptive claim? 9. □ YES □ NO

10. Failed to comply with any laws dealing with the practice of occupational therapy? 10. □ YES □ NO

11. How long have you been acquainted with the applicant? 11. _____ Years
_____ Months

12. Describe the manner in which you are familiar with the applicant's clinical skills.

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13. I attest that the information provided is true to the best of my knowledge:

Name	Signature
Job Title	Date
Address	City/State/Zip
(______) Home Phone number	(______) Work Phone Number

If this form has been completed by someone who has not observed the applicant's clinical skills, it will be rejected and may delay the processing of this application.

DO NOT FORWARD THE COMPLETED FORM TO THE APPLICANT.
The completed **original** form must be returned directly to:

MD Board of Occupational Therapy
Spring Grove Hospital Center
55 Wade Avenue
Baltimore, MD 21228

(Rev. 9/18/02)

FAXED COPIES WILL NOT BE ACCEPTED.