

MARYLAND BOARD OF OCCUPATIONAL THERAPY

SPRING GROVE HOSPITAL • TUERK BUILDING, 2ND FLOOR

55 WADE AVENUE • BALTIMORE, MARYLAND 21228

Phone 410-402-8560 • Fax 410-402-8561 • www.health.maryland.gov/botp

CHANGE OF INFORMATION REQUEST

Per COMAR 10.46.01.02, an applicant or licensee shall report a change of electronic mail address, postal address, or change of name, in writing, within 30 days of the change. The Board must, by law, have a valid address/name for you. The address/name that you provide is the "address/name of record" that is available for public information requests. Please provide a full mailing address, electronic address and phone number at which you can be reached during the day. The Board is authorized to proceed with its duties, including discipline, after it has attempted to contact you at the address of record, with or without your participation. Failure to notify the Board of an address/name change may result in your failure to receive a renewal application, which may in turn lead to disciplinary action for practicing on an expired license. Untimely notification to the Board of information changes may result in a late fee of \$50.

Name:	License Number:			
Notice for Mailing Lists				
The information collected is for the purposes of the Board's functions under Annotated Code of Maryland 10.46.01.02. You have a right to inspect, amend, and correct this information. The Board may permit inspection of this information or make it available to others only as permitted by federal and State law. The Board may sell or provide a list of licensees' names and addresses to professional associations and other entities. Under the Maryland Public Information Act, MD State Government Code Ann. §10-617, you may request in writing that your name be omitted from such lists.				
PLEASE DARKEN THE APPROPRIATE CIRCLE				
<input type="radio"/> Name	<input type="radio"/> Home Address	<input type="radio"/> E-mail Address	<input type="radio"/> Home Phone	<input type="radio"/> Work Phone
NAME CHANGE				
Previous Name:	New Name:			
<i>If you are requesting a change of name, please submit a copy of a legal name change document, marriage certificate, or divorce decree.</i>				
ADDRESS CHANGE				
Old Mailing Address	New Mailing Address			
Street:	Street:			
City:	City:			
State:	Zip code:	State:	Zip code:	
PHONE NUMBER CHANGE				
New Home or Cell Number:	New Work Number:			
E-MAIL ADDRESS CHANGE				
New E-mail Address:	Business Email:			
I affirm that the contents of this document are true and correct to the best of my knowledge and belief. Further, I authorize the Board to update their records to reflect this information.				
<input type="radio"/> I am moving out of state and will not be practicing in Maryland.				
Signature: _____	Date: _____			
For Office Use: Date Received: _____ Date Processed: _____				