



APPLICATION FOR ADVANCED PRACTICE APPROVAL – HAND THERAPY

(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)

Last Name	First Name	Middle Name
Residence Address	City	State Zip Code
Home Phone	Business Phone	E-Mail
Current Employer	Supervisor Name	Your OT Number

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 III: POST PROFESSIONAL EDUCATION AND TRAINING SUMMARY SHEET – <u>HAND</u> <u>THERAPY:</u>

HAND THERAPY EDUCATION (Minimum of 45 Contact Hours Required*):

of Hours: Course Title:

_____ Total Contact Hours

HAND THERAPY TRAINING (Minimum of 480 Supervised Hours Required*):

of Hours: Name of Facility:

* Eight (8) hours of education and sixty (60) hours of supervised on the job training in physical agent modalities can be applied towards meeting the education and training requirements for hand therapy. No other courses or hours can count for advanced practice approval in both hand therapy and physical agent modalities.

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 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 extrinsic muscle 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.

A Copy of Certificate of Completion must be attached for <u>each</u> 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 hand therapy. 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 ex	experience in <i>hand therapy</i> acquired between
(month/day/y	ear) and	(month/day/year).
Supervisor's Name:		
License Type/Number:	., OT, SLP, MD	Supervisor's Phone #:
Name and Address of Facility Where Training Occurred:		
IS OT applicant's name	competent	it in providing hand therapy?
— .		ated in the area of hand therapy. npetence in the area of hand therapy.
Please identify the knowledge	e, skills and abi	ilities demonstrated by the OT:
By signing below, YOU certify and that the timeframes and I		the clinical supervisor for training hours noted above e true and correct.
Supervisor's Signature:		Date:

Note to Supervisor:

Until the Board approves this applicant, you have <u>continuing</u> supervisory responsibility even if the "training" period has ended, IF the OT is providing Hand Therapy, and you are both employed at the location named above.