

# Wisconsin Department of Safety and Professional Services

**Mail To:** P.O. Box 8935  
Madison, WI 53708-8935  
**Fax #:** (608) 251-3036  
**Phone #:** (608) 266-2112

**Office Location:** 4822 Madison Yards Way  
Madison, WI 53705  
**E-Mail:** [dsps@wisconsin.gov](mailto:dsps@wisconsin.gov)  
**Website:** <http://dsps.wi.gov>

## OCCUPATIONAL THERAPISTS AFFILIATED CREDENTIALING BOARD OCCUPATIONAL THERAPIST OR OCCUPATIONAL THERAPY ASSISTANT CERTIFICATE OF PROFESSIONAL EDUCATION

**APPLICANT:** Complete this section and submit to certifying school for completion. Form must be returned directly from the school to the Department.

**Application Type:**  Occupational Therapist  Occupational Therapy Assistant

Last	First Name	MI	Former / Maiden Name(s)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Address (number/street)	(city)	(state)	(zip code)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Date of Birth	Social Security Number (voluntary-for use by school to locate your records)	Date of Graduation (Anticipated dates of graduation will not be accepted.)
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

**Application Number**

**ATTESTATION OF APPLICANT:** I declare that I am the person referred to on this form and that all information required to be completed by me (the applicant for a credential), is complete and accurate to the best of my knowledge and belief. Furthermore, I declare that after completing the information that was required by me (and only that information) the form was forwarded to the relevant third-party for completion of the information asked of them. I also declare that to the best of my knowledge the completed form was provided to the Department of Safety and Professional Services by the relevant third-party (and not by me, the applicant). Finally, I declare that I understand that failure to provide the requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential may result in credential application processing delays; denial, revocation, suspension, or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. By signing below, I am signifying that I have read and understand the above declarations.

<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
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**Applicant Signature**

**Date**

(If unable to provide a digital signature, please print and sign form.)

**CERTIFYING SCHOOL:** Complete this section for the above-named applicant and return directly to the Department using the License Third-Party\* Upload Portal at [license.wi.gov](http://license.wi.gov). You will need the application number shown above. (\*For form completion purposes, the term "Third-Party" refers to any non-applicant or non-DSPS individual or entity submitting required documentation in support of a credential application.)

<b>Name of School</b>	<input type="text"/>
<b>Location of School (City, State)</b>	<input type="text"/> <input type="text"/>
<b>Type of Degree Awarded</b>	<input type="text"/>
<b>Major</b>	<input type="text"/>
<b>Date of Graduation</b>	<input type="text"/> / <input type="text"/> / <input type="text"/> (Anticipated dates of graduation will not be accepted.)

*Continued on next page.*

# Wisconsin Department of Safety and Professional Services

**ATTESTATION OF THIRD-PARTY PROVIDING INFORMATION RELATED TO APPLICANT:** I declare, on behalf of the third-party asked to provide information related to the applicant identified on this form, that the information provided is true and correct to the best of my knowledge and belief. I further declare that after completing the form I, or other third-party staff, will provide the completed form directly to the Wisconsin Department of Safety and Professional Services for review. By signing below, I am signifying that I have read, understand, and have complied with the above declarations.

 /  / 

**Signature of Dean or Department Head**

**Date**

(If unable to provide a digital signature, please print and sign form.)

 -  -  Ext \_\_\_\_\_

**Printed Name**

**Phone**

**Title**