MISSISSIPPI STATE DEPARTMENT OF HEALTH

Supervision Agreement for Limited Permit Applicants

Print or Type Only

Limited Permit Applicant:

Name: _____

Home Address: _____

_____

(City) *(State)* *(Zip Code)*

Employer Name: _____

Employer Address: _____

_____

(City) *(State)* *(Zip Code)*

Facility/Agency Name, Address and Telephone Number (Once licensed, the applicant may only practice at the facilities/with the home health agencies listed on this form. Additional practice sites may be listed on a sheet of paper and attached to the form.)

1. _____

_____

_____

_____

2. _____

_____

_____

_____

3. _____

_____

_____

_____

Supervisor:

Name: _____

License #: _____

Beginning Date of Supervision: _____/_____/_____

I hereby certify and affirm, under the penalties of perjury, that the information on this form is correct. I understand that, as an occupational therapist, I may practice only under the supervision of the above named supervisor, or, as an occupational therapy assistant, practice under the above named supervisor in accordance with the supervision provisions for occupational therapy assistants listed in Subchapter 10 of the Regulations Governing Licensure of Occupational Therapists and Occupational Therapy Assistants in the facilities/agencies listed on this form and only after a temporary license is issued to me.

_____ _____

(Applicant's Signature) *(Date)*

I hereby certify and affirm, under the penalties of perjury, that the information contained on this form is correct and that I will provide supervision for this applicant at all times when practicing at the listed facilities/agencies. I understand and accept fully that I am responsible for the practice of the applicant once temporary license has been issued. I agree that I will contact the Professional Licensure Office, in writing, and provide copies to the supervisee and to the administrators of the facilities/agencies listed on this agreement within three (3) days of the termination of this agreement.

_____ _____

(Supervisor's Signature) *(Date)*

Upon completion the supervisor should mail this form to the:

Mississippi State Department of Health
Professional Licensure - OT
Post Office Box 1700
Jackson, Mississippi 39215-1700