Missouri Board of Occupational Therapy
Continuing Competency Summary Report Form
Reporting Period: July 1, 2015 to June 30, 2017 – 24 CCCs needed
Please print or type in black ink.

Name of Licensee: _____ **License No**.: _____ OT or OTA (circle one)

Practice setting/area: _____

Activity Date	Continuing Competency Activity/ Activity Title	Activity Sponsor/Location	Activity Category (see attached chart- A, B,C etc)	Number of CCC's	Audit Documentation attached - yes/no

TOTAL CCCs_____