



State of Maine
Department of Professional & Financial Regulation
Office of Professional & Occupational Regulation

COVID-19 EMERGENCY TEMPORARY REINSTATEMENT REQUEST

APPLICANT INFORMATION (please print)

FULL LEGAL NAME:

FIRST

MIDDLE INITIAL

LAST

MAILING ADDRESS

CITY

STATE

ZIP

PHONE #

FAX #

E-MAIL

()

()

**PLEASE INDICATE THE TYPE AND NUMBER OF THE MAINE
LICENSE YOU WISH TO TEMPORARILY REACTIVATE:**

- | | |
|--|--|
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Pastoral Counselor |
| <input type="checkbox"/> Audiologist | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> Certified Deaf Interpreter | <input type="checkbox"/> Pharmacy Intern |
| <input type="checkbox"/> Certified Interpreter | <input type="checkbox"/> Pharmacy Technician |
| <input type="checkbox"/> Certified Professional Midwife | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Podiatrist |
| <input type="checkbox"/> Clinical Professional Counselor | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Dietitian | <input type="checkbox"/> Radiologic Technologist |
| <input type="checkbox"/> Hearing Aid Dealer & Fitter | <input type="checkbox"/> Respiratory Care Technician |
| <input type="checkbox"/> Licensed Alcohol & Drug Counselor | <input type="checkbox"/> Respiratory Care Therapist |
| <input type="checkbox"/> Licensed Clinical Social Worker | <input type="checkbox"/> Speech-Language Pathologist |
| <input type="checkbox"/> Marriage & Family Therapist | <input type="checkbox"/> Speech-Language Pathologist/
Audiologist |
| <input type="checkbox"/> Multi-Level Long Term Care
Administrator | <input type="checkbox"/> Veterinarian |
| <input type="checkbox"/> Naturopathic Doctor | |
| <input type="checkbox"/> Nursing Home Administrator | |
| <input type="checkbox"/> Occupational Therapist | |

MAINE LICENSE #:

Affirmation

I affirm that I held an active Maine license that was not a conditional license, was in good standing with this State and not subject of any outstanding complaint or open investigation when the license terminated, and had no disciplinary or adverse action in the past ten years involving loss of license, probation, restriction, or limitation.

By my signature, I hereby certify that the information provided is true and accurate to the best of my knowledge and belief. By submitting this, I affirm that the Office of Professional and Occupational Regulation will rely upon this information for issuance of an Emergency Temporary License and that this information is truthful and factual. I also understand that this Emergency Temporary License will only remain valid until 60 days after the conclusion of the declared state of civil emergency unless surrendered.

SIGNATURE: _____ DATE: _____