

DEPARTMENT OF HEALTH
BOARD OF ORTHOTISTS AND PROSTHETISTS
4052 Bald Cypress Way, Bin # C07
Tallahassee, Florida 32399-3257
850/245-4355

APPLICATION INSTRUCTIONS

Please read these instructions and the laws governing the practice of orthotics and prosthetics before completing your application. Within 30 days receipt of your application, you will be sent a written application status notice. **You can also visit the board's web site for additional information at www.doh.state.fl.us/mqa/OrthPros/index.html**

GENERAL INFORMATION - APPLICABLE APPROVED EXAMINATIONS

Orthotist - American Board for Certification in Orthotics and Prosthetics, Inc. (ABC)

Orthotic Fitter - Trulife Institute for Applied Technology (TIAT) or Surgical Applied Institute (SAI)

Orthotic Fitter Assistant - Trulife Institute for Applied Technology (TIAT) or Surgical Applied Institute (SAI)

Pedorthist - Board for Certification in Pedorthics (BCP) or American Board for Certification in Orthotics and Prosthetics, Inc. (ABC)

Prosthetist - American Board for Certification in Orthotics and Prosthetics, Inc. (ABC)

Prosthetist-Orthotist - American Board for Certification in Orthotics and Prosthetics, Inc. (ABC)

GENERAL REQUIREMENTS - Every applicant for examination for licensure shall prove the following qualifications:

- (1) Eighteen years old;
- (2) Good moral character;
- (3) Completed the appropriate educational preparation, including practical training required, for which the license is sought;
- (4) Successfully completed an appropriate clinical internship/residency in the professional area(s) for which the license is sought

APPLICATION PROCESSING:

No application is complete until all required documentation and fees are received. Every question on the application must be answered. All documents and photos become a permanent part of your file and cannot be returned. You will be notified in writing if any additional documentation is required to complete your application. Applications are reviewed in date order received and **written** notice of application status will be sent to you at the mailing address you give in your application. The Board office must be notified **IMMEDIATELY** in writing of any changes to your application. Failure to do so could result in the denial of the application or revocation of licensure. **EXAMPLES:** change of address, employment, licensure status in another state, or an incorrect answer to a question. As a reminder to all applicants, please understand that Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

APPLICANT HISTORY:

The Board of Orthotists and Prosthetists understands that mental health counseling or treatment is a part of many persons' lives and such counseling or treatment does not disqualify an applicant from the practice of orthotics, prosthetics, or pedorthics. Furthermore, the Board does not wish to pry into the private affairs of an applicant. However, the Board is obligated to determine whether an applicant is physically and mentally fit to practice orthotics, prosthetics, or pedorthics. The Board is not seeking disclosure of counseling or treatment for a dramatic or upsetting event such as death, breakup of a relationship or a personal assault, even if such event does affect the applicant's ability to practice for a limited time.

MAILING ADDRESS:

List your complete mailing address, including street and apartment numbers and zip codes. The mailing address given in your application is where any correspondence from this office will be sent, including the permanent license. You can utilize a P.O. Box or practice mailing address in lieu of a home address if you want to avoid having your home address listed on the Web Site. If there is a change in your mailing address, you must submit any change **in writing**. Include in your letter your full name, your social security number, the complete new address and new telephone numbers.

LICENSE EXPIRATION DATE:

Licenses expire on November 30 of every odd-numbered year.

SOCIAL SECURITY NUMBER:

Mandatory disclosure of social security numbers pursuant to Federal Law:

Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. **In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, Sections 653 and 654; and Sections 456.013, 409.2577, and 409.2598, Florida Statutes.** Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to assure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for licensee identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L. 193, Section 317.

FINGERPRINT CARD/BACKGROUND CHECK: The Division of Medical Quality Assurance began scanning fingerprint cards and electronically submitting fingerprints to FDLE/FBI for background screening. The FDLE/FBI fee is \$48.00. Two properly executed fingerprint cards must be submitted with this application. The fingerprint cards will be used by the Florida Department of Law Enforcement (FDLE) and Federal Bureau of Investigation (FBI) to conduct a background check as required by law. See the instructions below for the proper procedures for completing/executing the fingerprint card. Failure to accurately follow these instructions may result in additional costs, which must be borne by you, and will result in a significant processing delay. Fingerprint cards can only be provided by mail. To obtain the fingerprint card you need to log on to www.fldoh.sofn.net

DOCUMENTATION AND FEES REQUIRED FOR LICENSURE
All documents must have original signature

- 1) **FEES:** Licensure for all licensure levels - \$1053
(\$500 Application fee + \$500 Licensure fee + \$48 FDLE/FBI Background Check + \$5 Unlicensed Activity fee)
If exam required: add \$500 Examination fee

The above fees must accompany the application or the application will not be processed. **ALL FEES MUST BE SUBMITTED WITH THE APPLICATION.** All fees include a non-refundable application fee; however, the licensure fee may be refunded if you are denied licensure or fail the exam. Make certified check or money order payable to **DOH - Board of Orthotists and Prosthetists**. The FDLE/FBI background check processing fee is also non-refundable once initiated. Background checks are initiated upon receipt of applications.

- 2) **APPLICATION FORM.** The application is 3 pages long.
- 3) **PHOTO:** One 2"X 2" photograph. HEAD AND SHOULDERS SHOTS ONLY. No casual photos.
- 4) **PROOF OF GRADUATION:**
- Graduates of U.S. schools must submit:
 - Official transcript with seal of the school registrar, including degree and date of graduation, submitted directly to the board office by the school. **NOTE: A COPY OF YOUR DIPLOMA IS NOT SUFFICIENT PROOF OF EDUCATION**
 - Graduates of foreign schools must submit:
 - Certified copy of the original transcript and seal.
 - Certified translations of any document in a language other than English.
 - Foreign credentials evaluation by board approved evaluators (See attached)

If requirements for graduation have been met but the official ceremony for graduation has not been held, the Board will accept a letter from the director of the program and seal of the registrar stating that you **have met graduation requirements**. This letter must be addressed to the Florida Board of Orthotists and Prosthetists.

- 5) **VERIFICATION OF CLINICAL EXPERIENCE:**
If you have previously worked in a job related to Orthotics, Prosthetics, or Pedorthics, your employer(s) must complete and submit the attached Verification of Employment form. The board reserves the right to verify employment relative to these professions for the previous five years.
- 6) **VERIFICATION OF LICENSURE FROM ANOTHER STATE:**
If you are now or have ever been licensed to practice as an Orthotist, Prosthetist, or Pedorthist in another state, you must request that each state complete the enclosed verification form and return it directly to the Florida Board of Orthotists and Prosthetists. **It is your responsibility to notify the state and pay any fees required by the other licensing state for this service.** You may make copies of this form if necessary. **NOTE:** A copy of your license from another state is **not** acceptable as verification.
- 7) **VERIFICATION OF ANY FOREIGN LICENSE THAT YOU HOLD OR HAVE EVER HELD:**
The verification, with an English translation, must be sent directly to the Florida Board. A notarized copy of your foreign license, with a translation into English is acceptable.
- 8) **COURSE VERIFICATION IN PREVENTION OF MEDICAL ERRORS:** Board approved 2 Hour Course on Prevention of Medical Errors.
- 9) **PROFESSIONAL LETTERS OF RECOMMENDATION:**
You must submit TWO (2) letters of recommendation. The requirements for acceptable letters of recommendation are as follows: They must be addressed to the "Board of Orthotists & Prosthetists" as opposed to "To whom it may concern" "Dear sir's", etc. They must be on letterhead paper from the individual writing the letter or the institution with which the individual is associated. They must be from individuals who are familiar with your professional and personal qualifications; they may not be from a relative. The letters can be sent with the application if they are in a sealed envelope, but must be no more than six (6) months old.
- 10) **FINGERPRINT CARD/BACKGROUND CHECK:** The Division of Medical Quality Assurance began scanning fingerprint cards and electronically submitting fingerprints to FDLE/FBI for background screening. The FDLE/FBI fee is \$48.00. Two properly executed fingerprint cards must be submitted with this application. The fingerprint cards will be used by the Florida Department of Law Enforcement (FDLE) and Federal Bureau of Investigation (FBI) to conduct a background check as required by law. See the instructions below for the proper procedures for completing/executing the fingerprint card. Failure to accurately follow these instructions

may result in additional costs, which must be borne by you, and will result in a significant processing delay. Fingerprint cards can only be provided by mail. To obtain the fingerprint card you need to log on to www.fldoh.sofn.net

NOTE: Language interpretation services are available to applicants for licensure who have limited-English proficiency or a hearing/speech impairment. If you need an interpreter in order to talk with your application processor, please indicate that information when you call the board office. An interpreter and the processor will call you back shortly in order to handle your call.

COMPLETING THE FINGERPRINT CARD

The Division of Medical Quality Assurance began scanning fingerprint cards and electronically submitting fingerprints to FDLE/FBI for background screening. The FDLE/FBI fee is \$48.00. To obtain a fingerprint card you to log on to www.fldoh.sofn.net

1. Complete **ONLY the following blocks** on the front of the fingerprint card (leave all other blocks blank):

Name (last, first, middle)	Signature of Person Fingerprinted	Aliases (AKA...nicknames)
Residence of Person Fingerprinted	Date of Birth	Citizenship
Sex	Race	Height
Weight	Color of Eyes	Hair Color
Place of Birth (City & State/Country)	Social Security Number	

2. Take the completed fingerprint card to your nearest Law Enforcement Agency. Be prepared to pay a fee for having the fingerprint card executed as some law enforcement agencies/departments do charge for executing fingerprint cards, and these costs must be born by you. The fingerprints must be taken by an appropriately trained law enforcement official. The fingerprint card must also be signed by a law enforcement official in the appropriate block. Please be advised, however, that you may be required to submit additional fingerprint cards should your initial fingerprint card be rejected by the Florida Department of Law Enforcement or the Federal Bureau of Investigation. Please submit your fingerprint card to the board office as soon as possible, as Florida law will not allow the issuance of a license to practice until a report from the background check has been received by the board office. Discrepancies between the information contained in your application and the information received in the reports from the criminal history background check will cause a delay in the processing of your application and/or the issuance of your license, and may require a personal appearance before the Board.

3. The following may cause **REJECTION OR EXTREME DELAY IN PROCESSING** your fingerprint card:

- Low quality print by dot matrix printers
- Poor penmanship
- Use of **ANY** highlighter in entry block
- Entry not within boundaries of entry block
- Labels applied to **“Leave Blank”** areas
- Submission on nonstandard fingerprint card
- Use of Pencil or ink other than black
- Incomplete descriptive data (e.g. incomplete birth date)
- Missing Originating Agency Identifier (ORI)
- Fingerprints missing, out of sequence, of poor quality or rolled on back of card
- Fingerprints missing with no reason given

The FBI requires that all fingerprints images be present on fingerprint submissions. This includes ten rolled impressions and four plain impressions.

ACCEPTABLE FOREIGN CREDENTIALS EVALUATION SERVICES

1. JOSEF SILNY & ASSOCIATES
INTERNATIONAL EDUCATIONAL
CONSULTANTS
7101 SW 102 AVENUE
MIAMI, FL 33173
PHONE: (305) 273-1616
FAX: (305) 273-1338
2. FOUNDATION FOR INTERNATIONAL
SERVICES, INC.
14926 35th AVENUE WEST, SUITE 210
LYNWOOD, WA 98087
PHONE: (425) 248-2262
FAX: (425)248-2262
www.fis-web.com
3. EDUCATION CREDENTIAL
EVALUATORS, INC.
P. O. BOX 92970
MILWAUKEE, WI 53202-0970
PHONE: (414) 289-3400
FAX: (414) 289-3411
4. CENTER FOR APPLIED RESEARCH,
EVALUATION & EDUCATION, INC.
P.O. BOX 18358
ANAHEIM, CA 92817
PHONE: (714) 237-9272
FAX: (714) 237-9279
5. INTERNATIONAL EDUCATION
RESEARCH FOUNDATION, INC.
P. O. BOX 3665
CULVER CITY, CA 90231
PHONE: (310) 258-9451
FAX: (310) 342-7086
6. WORLD EDUCATION SERVICES, INC.
P.O. BOX 01-5060
MIAMI, FL 33101
PHONE: (305) 358-6688
www.wes.org
7. FOREIGN ACADEMIC CREDENTIALS
SERVICES, INC.
P. O. BOX 400
GLEN CARBON, IL 62034
PHONE: (618) 307-6036
(618) 656-5291
FAX: (618) 656-5292
8. WORLD EDUCATION SERVICES, INC.
BOWLING GREEN STATION
P.O. BOX 5087
NEW YORK, NY 10274-5087
PHONE: (212) 966-6311
FAX: (212) 739-6100
www.wes.org

WHEN REQUESTING AN EVALUATION, PLEASE REQUEST A SUBJECT BREAKDOWN. This list is updated annually. The board office is not responsible for changes in telephone numbers subsequent to publication of this application.

APPLICATION CHECKLIST

Use the following checklist to help ensure that you send in all necessary documentation for licensure in the State of Florida.

- _____ 1. APPLICATION FORM.
 - All questions answered on all required pages and if question not applicable, marked with N/A.
 - All "YES" answers accompanied by an explanation or affidavit, as instructed.
- _____ 2. FEES. (Please make certified check or money order payable to DOH – Board of Orthotists and Prosthetists).
- _____ 3. PHOTO. Attach (1) 2"X2" photo to application. HEAD AND SHOULDERS ONLY.
- _____ 4. ADDRESS. The correct mailing address is listed, in full. If there is ANY CHANGE IN ADDRESS during the application process, you must immediately notify the board office of any change in writing.
- _____ 5. PROOF OF GRADUATION AND TRAINING.
- _____ 6. VERIFICATION OF CLINICAL EXPERIENCE FORM(S). (Pedorthists shall also submit a patient log as reflected in Rule 64B14-4.003, Florida Administrative Code).
- _____ 7. VERIFICATION(S) OF LICENSE IN ANOTHER STATE OR COUNTRY.
- _____ 8. COURSE VERIFICATION IN PREVENTION OF MEDICAL ERRORS (www.CEBroker.com)
- _____ 9. LETTERS OF RECOMMENDATION - (2 required).
- _____ 10. PROOF OF PASSAGE OF THE APPLICABLE EXAMINATION must be sent directly from the organization.
- _____ 11. Verification of Courses completed through TIAT, SAI or Florida Association of Orthotics & Prosthetics, (FAOP), must be sent directly from the organization.
- _____ 12. Verification of completion of 120 hours of pedorthic training from an ABC or BCP approved course must be sent directly from the head of the training program.
- _____ 13. Fingerprint card/Background Check

RETURN APPLICATION, FEES, AND SUPPORTING DOCUMENTS TO:

FLORIDA DEPARTMENT OF HEALTH
BOARD OF ORTHOTISTS AND PROSTHETISTS
POST OFFICE BOX 6330
TALLAHASSEE, FLORIDA 32314-6330

ADDITIONAL DOCUMENTATION, NOT ACCOMPANIED BY A FEE, SHOULD BE SENT TO:

BOARD OF ORTHOTISTS AND PROSTHETISTS
4052 BALD CYPRESS WAY, BIN # C07
TALLAHASSEE, FLORIDA 32399-3257



CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Florida Department of Health Board of Orthotists & Prosthetists

This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under Chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.

Name: _____
 Last **First** **Middle**

Social Security Number: _____

APPLICANT HISTORY: (If you answer **YES** to the following questions, please provide additional sheets, the relevant dates and circumstances of such treatment and/or addiction along with the names and addresses of the medical practitioners or hospitals who performed such treatment.)

1. In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years? [] YES [] NO
2. In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment? [] YES [] NO
3. During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice within the past five years? [] YES [] NO
4. During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice? [] YES [] NO
5. In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years? [] YES [] NO
6. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice within the last five years? [] YES [] NO

4052 Bald Cypress Way, Bin # C07
Tallahassee, Florida 32399-3257



**BOARD OF ORTHOTISTS & PROSTHETISTS
APPLICATION FOR LICENSURE**

PLEASE PRINT OR TYPE IN BLACK INK OR APPLICATION WILL BE RETURNED

APPLICATION CATEGORY: (An application is required for each licensure area)

- Orthotist – Client 3103 Orthotic Fitter – Client 3104 Orthotic Fitter Assistant – Client 3105
 Pedorthist – Client 3106 Prosthetist – Client 3102 Prosthetist-Orthotist – Client 3101

PROFILE DATA:

1. **Name:** _____
(Last) (First) (Middle)

a. Have you changed your name through marriage or through action of a court, or have you ever been known by any other name?
 Yes No

If yes, list name(s) (Last, First, Middle) and Date(s) of change and attach a copy of the legal document

2. a. **MAILING ADDRESS:** _____
(Street and Number) (Apt. Number)

(City) (County) (State) (Zip Code)

b. **PRACTICE LOCATION:** _____
(Street and Number) (Apt. Number)

(City) (County) (State) (Zip Code)

3. **DRIVER LICENSE NUMBER AND STATE:** _____

4. **TELEPHONE:** (____) _____ (____) _____
Home: Area Code/Phone Number Work: Area Code/Phone Number

PERSONAL DATA:

a. E-mail Address: _____

b. Date of Birth: _____ c. Place of Birth: _____
(Month/Day/Year) (City/State/Country)

d. We are required to ask that you furnish the following information as part of you voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

RACE: Caucasian African-American/Black Hispanic Asian Native American Other
SEX: Male Female

e. Height: _____ Weight: _____ Eye Color: _____

- Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? Yes No

NAME: _____

6. APPLICANT REGISTRATION STATUS: (Attach additional sheets if necessary)

- a. Do you now hold or have held a license or certificate of registration to practice any profession under Chapter 468, Part XIV, F.S., in any state, U.S. territory or foreign country? Yes No

If yes, list all such licenses/registrations: State and License/Registration Number and date of original License/Registration. Complete a License Verification form for each license or registration. If License/Registration is not now in force, state how and when validity ceased.

APPLICANT HISTORY:

Have you passed a national certification examination? Yes No

If yes, which examination: _____ Date: _____

If no, give the date you are scheduled to sit and the name of examination: _____

7. ANSWER ALL QUESTIONS. DO NOT LEAVE ANY QUESTION BLANK. (Note: Any "yes" answers must be accompanied by an attached document explaining in detail the answer. This must include all pertinent information such as explanation(s), date(s), address(es), physician(s), institution(s), agency(ies), and hospital(s). Additional information may be requested, such as court documents, employment verification, evaluation letters from treating physicians, etc.)

- a. Have you ever been denied licensure in a health-related profession or any other profession? Yes No
- b. Have you had action filed against you relating to the practice of this profession or any health care profession? Yes No
- c. Have you had a license/registration/certification to practice any profession, revoked, suspended or otherwise sanctioned, including denial of licensure by the licensing authority of any state, territory, or country? Yes No
- d. Have you ever been named in a malpractice suite or sued for malpractice? Yes No
- e. Have you ever been disciplined, terminated or allowed to resign, in lieu of termination, from an employment setting where employed as an Orthotist/Prosthetist, etc., or in any capacity in any other profession? Yes No
- f. Have you ever lost your civil rights? Yes No (If yes, provide original court documents showing reinstatement.)
- g. To the best of you knowledge, is there any disciplinary action pending against you by any licensing board and/or professional organization? Yes No

Pursuant to Section 456.0635(2), Florida Statutes, the following questions are being asked. If you answer yes to any of the following questions, explain on a separate sheet providing accurate details and submit copies of supporting documentation.

- h. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396? YES NO (If no, do not answer i.)
- i. Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for each such conviction? YES NO
- j. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? YES NO (If no, do not answer k.)
- k. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? YES NO
- l. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? YES NO (If no, do not answer m and n.)
- m. Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years? YES NO
- n. Did the termination occur at least 20 years prior to the date of this application? YES NO

NAME: _____

- o. Have you ever entered a plea of guilty or nolo contendere to, or been convicted of a crime? Include all misdemeanors and felonies, even if adjudication was withheld. [] Yes [] No (If yes, provide a certified copy of arrest records and court disposition documents.)
- p. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if, adjudication was withheld by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purpose of this question. [] Yes [] No (If yes, provide a certified copy of arrest records and court disposition documents.)
- q. Have you ever been requested to leave, temporarily or permanently, an educational training program prior to the completion of the program? [] Yes [] No
- r. Have you ever been arrested or criminally or civilly charged with any intentional or negligent action related to the use or misuse of drugs, alcohol, or illegal chemical substances? [] Yes [] No

8. UNDERGRADUATE AND GRADUATE EDUCATION INFORMATION: (Provide additional sheets if necessary)

Name and Location of Institution: _____ Dates of Attendance: _____

Type of Degree Earned and Date Received: _____

Name and Location of Institution: _____ Dates of Attendance: _____

Type of Degree Earned and Date Received: _____

Name and Location of Institution: _____ Dates of Attendance: _____

Type of Degree Earned and Date Received: _____

Name and Location of Orthotic or Prosthetic Certification Institution: _____

9. RESIDENCY/INTERNSHIP: (Provide additional sheets if necessary)

Name and Location of Institution: _____ Dates of Attendance: _____
_____ Number of Hours Completed: _____

Name and Location of Institution: _____ Dates of Attendance: _____
_____ Number of Hours Completed: _____

Name and Location of Institution: _____ Dates of Attendance: _____
_____ Number of Hours Completed: _____

NAME: _____

10. STATEMENT OF APPLICANT:

The information contained in this application is true and accurate. I hereby authorize all my references, personal physicians, educational institutions, employers, business and professional organizations and associates, past and present, to release to the Department of Health any information requested in connection with the processing of this application. I understand that it is my duty and responsibility as an applicant for licensure to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the Department's decision concerning my eligibility for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservation of any kind, and I declare that my answers and all statements made by me herein are true and correct and that the photograph attached to the application is a photograph of me. Should I furnish false information on this application, I understand that such action shall constitute cause for the denial, suspension or revocation of licensure to practice for which I am applying in the state of Florida.

I will comply with all requirements for licensure renewal in effect at the time of license renewal including submission of appropriate renewal fees and continuing education credit. As a reminder to all applicants, please understand that Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

(Signature of Applicant)

(Date)

NOTE: It is a third degree felony to knowingly give false information in the course of applying for or obtaining a license from the department, with the intent to mislead a public servant in the performance of his/her official duties. Section 456.067, Florida Statutes.



LICENSE VERIFICATION FORM

TO BE COMPLETED BY APPLICANT: Complete this part and submit a copy to each state where you hold or have held a license to practice a profession regulated under Chapter 468, Part XIV, F.S.. Please make copies of this form, if necessary. Please print or type in black ink.

APPLICANT NAME: _____

ADDRESS: _____
(Street and Number) (Apt. Number) (City) (State) (Zip)

TITLE OF LICENSE: _____ **LICENSE NUMBER:** _____



TO BE COMPLETED BY THE STATE LICENSING BOARD OFFICE AND MAILED TO:

- Board of Orthotists and Prosthetists
4052 Bald Cypress Way, Bin #C07
Tallahassee, Florida 32399-3257

The individual listed above has applied for licensure in Florida. Before further consideration is given to this application, we need the information requested on this form.

TITLE OF LICENSE: _____ **LICENSE NUMBER:** _____

ORIGINAL ISSUE DATE: _____ **EXPIRATION DATE:** _____

LICENSE STATUS: Active Inactive Temporary Other, _____

LICENSURE METHOD: Grandfathering Endorsement Examination

If licensed by examination, complete the following:

Name of Examination: _____ Level of Examination: _____

Date of Examination: _____ Score Achieved: _____

Has any disciplinary action been taken against this license? Yes No

If yes, provide our office with any documentation regarding the disciplinary action.

Do you have any derogatory information concerning this person? Yes No

If yes, explain.

**STATE
SEAL**

(Signature) (Title)

(Date) (Phone Number)

(Board of) (State of)



VERIFICATION OF CLINICAL EXPERIENCE FORM

This form should be used to document clinical experience and may be duplicated as necessary. Please print or type in black ink.

TO BE COMPLETED BY APPLICANT:

APPLICANT NAME: _____

- Orthotist – Client 3103 Orthotic Fitter – Client 3104 Orthotic Fitter Assistant – Client 3105
 Pedorthist – Client 3106 Prosthetist – Client 3102 Prosthetist-Orthotist – Client 3101

TO BE COMPLETED BY APPLICANT'S EMPLOYER:

- General Information

Employer's Name: _____ Phone Number: _____

Address: _____

- Work Experience

Dates of the applicant's work experience: _____
(From: Month/Day/Year) (To: Month/Day/Year)

Complete description of job responsibilities as applied to license categories:

TO BE COMPLETED BY APPLICANT'S SUPERVISOR:

- Certification by Supervisor

Supervisor's Name: _____

Florida License Number: _____ ABC Certification Number: _____
(If supervisor is not licensed in Florida, provide ABC Certification Number)

The above information is true and correct to the best of my knowledge.

(Signature of Supervisor)

(Date)