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

# LICENSE 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**

## 1. GENERAL INFORMATION –

### a. Applicable Approved Examinations:

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

### b. Applicable Approved Training:

- **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)

## 2. GENERAL REQUIREMENTS - Every applicant for licensure shall prove the following qualifications:

- At least eighteen years old;
- Good moral character;
- Completed the appropriate educational preparation, including practical training required, for which the license is sought;
- Successfully completed an appropriate clinical internship/residency in the professional area(s) for which the license is sought, if applicable.

## 3. APPLICATION PROCESSING:

**No application is complete until all required documentation and fees are received.** Every question on the application must be answered. All documents 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. All documents must have original signatures. As a reminder to all applicants, please understand that Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

## 4. 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.

## 5. 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.

## 6. FEE SCHEDULE – (Fees for all licensure levels):

| Fee | Amount |
|---|---|
| Application | $ 500.00 |
| Licensure | $ 500.00 |
| FDLE/FBI Background Check | $ 43.00 |
| Unlicensed Activity | $ 5.00 |
| **Total Fee** | **$1048.00** |

***Examination $ 500.00 (additional fee)** – Board approved examination fee

*Please submit the additional fee to take the Florida Board approved prosthetics, orthotics or pedorthics examination through the Board, if you have not successfully completed the required examination. **The total amount submitted is $1,548.00.**

The application fee is non- refundable; however, if you are denied licensure or fail the examination the licensure and unlicensed activity fee may be refunded.

7. **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 $43.00. One** properly executed fingerprint card must be submitted with this application. The fingerprint card 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. To obtain the fingerprint card and instructions, please log on to www.fldoh.sofn.net.

8. **PROOF OF EDUCATION AND TRAINING:**

a. **PROSTHETIST, ORTHOTIST, and PROSTHETIST-ORTHOTIST**
**Graduates of U.S. schools must submit:**
- Official transcript(s) 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.

**Training:**
- If your degree in not in prosthetics, orthotics, or prosthetics-orthotics, you will need to submit documents directly to the board from a CAHEEP approved institution demonstrating proof of completion of a certificate training course in prosthetics or orthotics.
- Documentation evidencing completion of a Board approved residency or internship in the appropriate field.

b. **ORTHOTIC FITTER and ORTHOTIC FITTER ASSISTANT**
**Graduates of U.S. schools must submit:**
- A copy of your high school diploma or a certified GED certificate

**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)

**Training:**
- Official documentation, including date of graduation, submitted directly to the board by the school or certificate of completion. **NOTE: A COPY OF YOUR DIPLOMA IS NOT SUFFICIENT PROOF OF EDUCATION**

c. **PEDORTHIST**
**Graduates of U.S. schools must submit:**
- A copy of your high school diploma or a certified GED certificate

**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)

**Training:**
- Official documentation submitted by the school directly to the board demonstrating a minimum of 120 hours of training. **NOTE: A COPY OF YOUR CERTIFICATE IS NOT PROOF OF TRAINING**
- Documentation demonstrating proof of completion of an internship of at least eighty (80) hours of work experience.
- Documentation of patient log in Rule 64B14-4.003, F.A.C.

9. **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 Verification of Clinical Experience form. The board reserves the right to verify employment relative to these professions for the previous five years.

10. **VERIFICATION OF LICENSURE:**
**Other State and Foreign License:**
If you hold or have held a license or certificate of registration to practice a healthcare profession in any state, U.S. territory or foreign country you must submit a completed Verification of Licensure 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. **NOTE:** A copy of your license from another state is **not** acceptable as verification. Verification forms not completed in English must be accompanied with an English translation.

11. **MANDATORY COURSES:**
Documentation of completion of the mandatory courses as required in Rule 64B14-5.005, F.A.C. Please visit CEBroker at www.cebroker.com
   - Florida Laws and Rules Course
   - Infection Disease Control Course
   - Prevention of Medical Errors Course
   - CPR Certification Course

12. **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". 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.

13. **LICENSE EXPIRATION DATE:**
Licenses expire on November 30 of every odd-numbered year.

**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.**

Please submit a certified check, or money order in the appropriate amount, made payable to the Florida Department of Health to the following address:

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

## ACCEPTABLE FOREIGN CREDENTIALS EVALUATION SERVICES

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.

Josef Silny & Associates – International Educational Consultants
7101 SW 102 Avenue
Miami, FL 33173
Phone: (305) 273-1616
Fax: (305) 273-1338

Education Credential Evaluators, Inc.
P. O. Box 92970
Milwaukee, WI 53202-0970
Phone: (414) 289-3400
Fax: (414) 289-3411

International Education Research Foundation, Inc.
P. O. Box 3665
Culver City, CA 90231
Phone: (310) 258-9451
Fax: (310) 342-7086

Foreign Academic Credentials Services, Inc.
P. O. Box 400
Glen Carbon, IL 62034
Phone: (618) 307-6036 or (618) 656-5291
Fax: (618) 656-5292

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

Center for Applied Research, Evaluation & Education, Inc.
P.O. Box 18358
Anaheim, CA 92817
Phone: (714) 237-9272
Fax: (714) 237-9279

World Education Services, Inc.
P.O. Box 01-5060
Miami, FL 33101
Phone: (305) 358-6688
www.wes.org

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

# 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 or 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

# 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

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**APPLICANT PROFILE:**

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. **ADDRESS:**

a. **MAILING ADDRESS:** (where you receive your mail)

______________________________________________
(Street and number or PO Box) (Apt Number)

______________________________________________
(City) (County) (State/Province) (Zip/Postal Code) (Country)

b. **PRIMARY PRACTICE/PHYSICAL ADDRESS** (where you can be located-NO PO BOX):

______________________________________________
(Street and number) (Ste Number)

______________________________________________
(City) (County) (State/Province) (Zip/Postal Code) (Country)

c. **TELEPHONE:** _(______)_______________________ _(______)_______________________
Primary: Area Code/Phone Number Business: Area Code/Phone Number

d. **EMAIL ADDRESS:** ______________________________________________

3. **PERSONAL DATA:**

BIRTH DATE: ____________________ BIRTH PLACE: ______________________________
(MM/DD/YYYY) (City) (State/Province) (Country)

**We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniformed Guidelines on Employee Selection Procedure (1978) 43 FR38296 (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: White [ ] Black [ ] Hispanic [ ] Asian/Pacific Islander [ ] Native American [ ] Other [ ]
SEX: Male [ ] Female [ ]

- Would you be willing to provide health services in special needs to shelters or to help staff disaster medical assistance teams during time of emergency or major disaster? [ ] YES [ ] NO

NAME: ______________________________

4. **APPLICANT HISTORY: (Attach additional sheets if necessary)**

Do you now hold or have held a license, certificate, or registration to practice any healthcare profession, in any state, U.S. territory or foreign country? [ ] YES [ ] NO

If YES, please list all such licenses/registrations:

| License/Registration Type | Number | State/Country | Original Date Issued | Expiration Date |
|---|---|---|---|---|
| ______ | ______ | ______ | ___/___/___ | ___/___/___ |
| ______ | ______ | ______ | ___/___/___ | ___/___/___ |
| ______ | ______ | ______ | ___/___/___ | ___/___/___ |

**(NOTE: Complete a License Verification Form for each license or registration above.)**

5. **EDUCATION:**

a. **ORTHOTIST & PROSTHETIST:**

**UNDERGRADUATE/GRADUATE/PROFESSIONAL EDUCATION:** Please provide undergraduate, graduate, and professional education, listing all schools, colleges and universities attended, whether completed or not, in chronological order.

| (School Name) | (City/State) | (From: MM/DD/YYYY – To: MM/DD/YYYY) | (Graduation Date) | (Degree Awarded) |
|---|---|---|---|---|
| (School Name) | (City/State) | (From: MM/DD/YYYY – To: MM/DD/YYYY) | (Graduation Date) | (Degree Awarded) |
| (School Name) | (City/State) | (From: MM/DD/YYYY – To: MM/DD/YYYY) | (Graduation Date) | (Degree Awarded) |

**CERTIFICATE IN ORTHOTICS or PROSTHETICS:** If your degree is not in Prosthetics and Orthotics, you must provide a certificate of completion from an approved institution, of training in prosthetics or orthotics, as appropriate.

| (Institution Name) | (City) | (State) |
|---|---|---|
| (From: MM/DD/YYYY – To: MM/DD/YYYY) | (Graduation Date) | (Certificate Awarded) |

b. **ORTHOTIC FITTER and ORTHOTIC FITTER ASSISTANT:**

Please provide high school/GED education.

| (School Name) | (City/State) | (From: MM/DD/YYYY – To: MM/DD/YYYY) | (Graduation Date) | (Degree Awarded) |
|---|---|---|---|---|
| (School Name) | (City/State) | (From: MM/DD/YYYY – To: MM/DD/YYYY) | (Graduation Date) | (Degree Awarded) |
| (School Name) | (City/State) | (From: MM/DD/YYYY – To: MM/DD/YYYY) | (Graduation Date) | (Degree Awarded) |

c. **PEDORTHIST:**

Please provide high school/GED education.

| (School Name) | (City/State) | (From: MM/DD/YYYY – To: MM/DD/YYYY) | (Graduation Date) | (Degree Awarded) |
|---|---|---|---|---|
| (School Name) | (City/State) | (From: MM/DD/YYYY – To: MM/DD/YYYY) | (Graduation Date) | (Degree Awarded) |
| (School Name) | (City/State) | (From: MM/DD/YYYY – To: MM/DD/YYYY) | (Graduation Date) | (Degree Awarded) |

NAME: ____________________________________________

**TRAINING PROGRAM:** Please complete the following information and provide an original letter from the head of a training program(s) approved by ABC attesting to the training as defined in Rule 64B14-4.110(3)(a), F.A.C.

___________________________________________________________________________
(Institution Name) (City/State) (From: MM/DD/YYYY – To: MM/DD/YYYY) (Hours Completed)

6. **TRAINING:** (complete only for the area of applying for licensure)

   a. **ORTHOTIST & PROSTHETIST RESIDENCY/INTERNSHIP:**

___________________________________________________________________________
(Facility Name) (City/State) (From: MM/DD/YYYY – To: MM/DD/YYYY) (Hours Completed)

___________________________________________________________________________
(Facility Name) (City/State) (From: MM/DD/YYYY – To: MM/DD/YYYY) (Hours Completed)

___________________________________________________________________________
(Facility Name) (City/State) (From: MM/DD/YYYY – To: MM/DD/YYYY) (Hours Completed)

   b. **PEDORTHIST:**

___________________________________________________________________________
(Facility Name) (City/State) (From: MM/DD/YYYY – To: MM/DD/YYYY) (Hours Completed)

___________________________________________________________________________
(Facility Name) (City/State) (From: MM/DD/YYYY – To: MM/DD/YYYY) (Hours Completed)

   c. **ORTHOTIC FITTER OR ORTHOTIC FITTER ASSISTANT:**

___________________________________________________________________________
(Approved Training Course) (From: MM/DD/YYYY – To: MM/DD/YYYY) (Hours Completed)

___________________________________________________________________________
(Approved Shoe Course) (From: MM/DD/YYYY – To: MM/DD/YYYY) (Hours Completed)

7. **EXAMINATION HISTORY: (Orthotist or Prosthetist ONLY)**

   a. Have you passed the ABC national certification examination? [ ] YES [ ] NO

**ALL AFFIRMATIVE ANSWERS MUST BE EXPLAINED IN DETAIL ON A SEPARATE SHEET. DOCUMENTATION SUBSTANTIATING THE EXPLANATION IS REQUIRED.**

## PROCEEDINGS and/or ACTIONS

**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.)**

8. **APPLICATION:**

   a. Have you ever been denied licensure in a health-related profession or any other profession? [ ] YES [ ] NO

9. **EDUCATION TRAINING:**

   a. Have you ever been requested to leave, temporarily or permanently, an educational training program prior to the completion of the program? [ ] YES [ ] NO

10. **LICENSURE:**

   a. 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

NAME: ____________________

b. Have you had action filed against you relating to the practice of this profession or any health care profession? [ ] YES [ ] NO

**11. MALPRACTICE:**

a. Have you ever been named in a malpractice suit or sued for malpractice? [ ] YES [ ] NO

**12. EMPLOYMENT:**

a. 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

**13. DISCIPLINE:**

a. To the best of your knowledge, is there any disciplinary action pending against you by any licensing board and/or professional organization? [ ] YES [ ] NO

**14. CRIMINAL PROCEEDINGS/ACTIONS: (If you answer YES, provide a certified copy of the arrest records and court disposition documents)**

a. 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

b. 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

c. 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

**IMPORTANT NOTICE: Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes.. If you answer YES to any of the following questions, please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation to the address below. Supporting documentation includes court dispositions or agency orders where applicable.**

**15.** Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felon offense(s) in another state or jurisdiction? **(If you responded NO, skip to 16)** [ ] YES [ ] NO

a. If "yes" to 15, for felonies of the first or second degree, has it been more than 15 years before the date of the plea, sentence and completion of any subsequent probation? [ ] YES [ ] NO

b. If "yes" to 15, for felonies of the third degree, has it been more than 10 years before the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes). [ ] YES [ ] NO

c. If "yes" to 15, for felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation? [ ] YES [ ] NO

a. If "yes" to 15, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? **(If "yes", please provide supporting documentation)** [ ] YES [ ] NO

NAME: ______________________________

16. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? [ ] YES [ ] NO

    a. If "yes" to 16, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation of such conviction or plea ended? [ ] YES [ ] NO

17. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **(If "No", do not answer 15a.)** [ ] YES [ ] NO

    a. 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

18. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? **(If "No", do not answer 18a or 18b.)** [ ] YES [ ] NO

    a. Have you been in good standing with a state Medicaid program for the most recent five years? [ ] YES [ ] NO

    b. Did the termination occur at least 20 years before to the date of this application? [ ] YES [ ] NO

19. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities? [ ] YES [ ] NO

20. If "yes" to any of the questions 15 through 19 above, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession's licensing board or the Department of Health?
**(If "yes", please provide official documentation verifying your enrollment status.)** [ ] YES [ ] NO

**21. 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. 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:** ______________________

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**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, ______________________

Has any disciplinary action been taken against this license? [ ] YES [ ] NO

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

STATE
SEAL

______________________________________________
(Signature) (Title)

______________________________________________
(Date) (Phone Number)

______________________________________________
(Board of) (State of)

DH-MQA 1132, 7/2012
Rule 64B14-4.003, F.A.C.

# 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

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**TO BE COMPLETED BY APPLICANT'S EMPLOYER:** (only provide information for which you have first-hand knowledge)

- General Information

  Employer's Name: ______________________________ Phone Number: ______________

  Address: ________________________________________
  (Street and Number or P.O. Box) (City) (State/Province) (Zip/Postal Code) (Country)

- 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: (if supervisor is not licensed in Florida, please provide ABC Certification Number)

  ________________________________________
  (Supervisor's Name-PRINT) (Florida License Number) (ABC Certification Number)

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

________________________________________
(Signature of Supervisor) (Date)

# MANDATORY COURSES

**TO:** **Florida Board of Orthotists & Prosthetists**
**4052 Bald Cypress Way, Bin #C07**
**Tallahassee, FL 32399-3257**

**FROM:** ______________________________________
**(Please type or print)**

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**I have completed the board approved mandatory educational courses** on the Prevention of Medical Errors, CPR Certification Course, Infection Disease Control Course, Laws and Rules Course. I understand that within the next two years I may be required to submit proof of my completion of this course if my license is selected for audit.

I understand that these statements are true and correct. I further understand and acknowledge that providing false information may result in the denial of my application, disciplinary and/or criminal penalties as provided in Florida Statutes 456.072, 456.067, 775.082, 775.083, or 755.084.

1. ______________________________ ______________________ ______________
**Prevention of Medical Errors Course Title** **Provider Name** **Date Completed**

2. ______________________________ ______________________ ______________
**CPR Certification Course Title** **Provider Name** **Date Completed**

3. ______________________________ ______________________ ______________
**Infection Disease Control Course Title** **Provider Name** **Date Completed**

4. ______________________________ ______________________ ______________
**Florida Laws and Rules Course Title** **Provider Name** **Date Completed**

______________________________________
**Applicant Signature (Required)**

______________________________________
**Date (of signature)**