FLORIDA DEPARTMENT OF HEALTH

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

APPLICATION INSTRUCTIONS
Internship/Residency Registration

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 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;

2. **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. 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.

3. **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.

4. **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.

5. **FEE SCHEDULE:**

Application	$250.00
Registration	$250.00
FDLE/FBIBackground Check	$ 48.00
Unlicensed Activity	$ 5.00
TOTAL FEE	**$553.00**

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

6. **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. One properly executed fingerprint card 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. To obtain the fingerprint cards and instructions, please log on to www.fldoh.sofn.net.

7. **PROOF OF GRADUATION AND TRAINING:**

PROSTHETIST, ORTHOTIST, and PROSTHETIST-ORTHOTIST

Graduates of U.S. schools must submit:

1. 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**
   a. 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

2. Applicants for initial registration **only**, having completed their degree requirements at a recognized prosthetics and orthotics degree program within forty-five (45) days of their registration application, and whose transcript is not yet available, may instead of an official transcript submit both of the following:
   a. A letter sent directly to the Board on school letterhead signed by the orthotics and prosthetics degree program's director, documenting the applicant has completed the prosthetic and orthotic's degree curriculum and is eligible and due to graduate, and specifying the degree to be awarded; and
   b. A copy of the applicant's request for a certified transcript addressed to be sent directly to be sent directly to the board.

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)

8. **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.

9. **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

10. **LICENSE EXPIRATION DATE:**
Please refer to Rule 64B14-4.100, F.A.C.

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

1. JOSEF SILNY & ASSOCIATES
INTERNATIONAL EDUCATIONAL
COUNSULTANTS
7101 SW 102 AVENUE
MIAMI, FL 33173
PHONE: (305) 273-1616
FAX: (305) 273-1338

2. EDUCATION CREDENTIAL
EVALUATORS, INC.
P.O. BOX 92970
MILWAUKEE, WI 53202-0970
PHONE: (414) 289-3400

3. INTERNATIONAL EDUCATION
RESEARCH FOUNDATION, INC.
P.O. BOX 66940
LOS ANGELES, CA 90066
PHONE: (310) 390-6276
PHONE: (310) 397-7686

4. FOREIGN ACADEMIC CREDENTIALS
SERVICES, INC.
P.O. BOX 400
GLEN CARBON, IL 62034
PHONE: (618) 288-1661

5. FOUNDATION FOR INTERNATIONAL
SERVICES, INC.
19015 NORTH CREEK PARKWAY, #103
BOTHELL, WA 98011-3975
PHONE: (206) 487-2245
FAX: (206) 487-1989

6. INTERNATIONAL CONSULTANTS
OF DELAWARE, INC.
109 BARKSDALE PROFESSIONAL CTR
NEWARK, DE 19711
PHONE: (302) 737-8715

7. CENTER FOR APPLIED RESEARCH,
EVALUATION & EDUCATION, INC.
P.O. BOX 20348
LONG BEACH, CA 90801
PHONE: (562) 430-1105

8. WORLD EDUCATION SERVICES, INC.
P.O. BOX 745
OLD CHELSEA STATION
NEW YORK, NY 10113-0745
PHONE: (212) 966-6311

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.

FLORIDA DEPARTMENT OF HEALTH

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

FLORIDA DEPARTMENT OF HEALTH

BOARD OF ORTHOTISTS & PROSTHETISTS
INTERNSHIP/RESIDENCY REGISTRATION

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

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

Profession: [ ] Orthotist –Client 3109 [ ] Prosthetist-Client 3110

Program: [ ] Internship [ ] Residency

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 [ ]

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. 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)

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.)

6. APPLICATION:

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

7. 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

8. 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

9. MALPRACTICE:

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

10. 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

11. 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

12. 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.

13. 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 14)** [ ] YES [ ] NO

a. If "yes" to 13, 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 13, 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 13, 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 13, 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: _____

14. 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 14, 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

15. 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

16. 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 16a or 16b.)** [ ] 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

17. 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

18. If "yes" to any of the questions 13 through 17 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

19. **SUPERVISOR'S INFORMATION (To be completed by Intern/Resident Applicant's Supervisor)**

(Supervisor's Name) (Florida License Number) (ABC Certification Number)

(Name of Practice) (Practice Telephone Number)

(Street Address) (City) (State) (Zip)

Date Internship/Residency Starts: _____ (MM/DD/YYYY) Date Internship/Residency Ends: _____ (MM/DD/YYYY)

I agree to supervise the referenced resident/intern in accordance with the requirements set forth in Rule 64B14-4.100, F.A.C. I further agree that if this supervision is terminated for any reason, I shall inform the Board in writing within five (5) business days, giving the reasons for the termination. Within 30 days of the conclusion of the supervision period I shall complete the Verification of Clinical Experience form confirming the completion of the training period. I will also include a detailed narrative of the Resident/Intern's work experience.

The above information is true and correct.

_____ _____

Signature of Supervisor Date

NAME: _____

20. INTERN/RESIDENT'S SIGNATURE

I agree to abide by the laws and rules of the state of Florida and to follow the direction of my supervisor in accordance to the requirements set forth by Rule 64B14-4.100, F.A.C. I further agree that if this supervision is terminated for any reason, I shall inform the Board in writing within five (5) business days. I will also include a detailed narrative of my work experience and reasons for early termination of supervision.

I, _____, certify the above information is true and correct.
Print Name

_____ _____
Signature of Internship/Residency Applicant Date

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.

FLORIDA DEPARTMENT OF HEALTH

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, _____

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)

FLORIDA DEPARTMENT OF HEALTH

Mandatory Courses

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

FROM: _____
(Please type or print)

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)