



Orthotist, Prosthetist, Prosthetist- Orthotist, Orthotic Fitter, Orthotic Fitter Assistant, Pedorthist – Application for Licensure

Board of Orthotists & Prosthetists
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: flidasorthotistsprosthetists.gov
Email: MQA.OrthoPros@flhealth.gov
Phone: (850) 245-4292
Fax: (850) 413-6982



Are you an active duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered "Yes" to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health's commitment to serving members and veterans of the United States Armed Forces and their families online at <http://www.flhealthsource.gov/valor>



**Orthotist, Prosthetist, Prosthetist-Orthotist,
Orthotic Fitter, Orthotic Fitter Assistant,
Pedorthist – Application for Licensure**

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P.O. Box 6330
Tallahassee, FL 32314-6330
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Do Not Write in this Space
For Revenue Receiving Only

Select one application type:

- | | |
|--|--|
| Prosthetist-Orthotist (3101) \$805.00 | Orthotic Fitter (3104) \$805.00 |
| Prosthetist (3102) \$805.00 | Orthotic Fitter Assistant (3105) \$805.00 |
| Orthotist (3103) \$805.00 | Pedorthist (3106) \$805.00 |

Total fee includes the following:

Application Fee	\$400.00
Initial Licensure Fee	\$400.00
Unlicensed Activity Fee	\$5.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. An applicant who is denied licensure or withdraws their application is entitled to a \$405.00 (Initial Licensure Fee and Unlicensed Activity Fee) refund. Requests to withdraw or for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

1. PERSONAL INFORMATION

Name: _____ Date of Birth: _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

Street/P.O. Box Apt. No. City

State ZIP Country Home/Cell Telephone (Input without dashes)

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website)

Street (Place of Employment) Apt. No. City

State ZIP Country Work/Cell Telephone (Input without dashes)

EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 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.

Gender: Male Race: Native Hawaiian or Pacific Islander Hispanic or Latino White
 Female American Indian or Alaska Native Black or African American Asian
 Two or More Races

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

Yes No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes (F.S.), authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

Social Security Number: _____
(Input without dashes)

Social Security Information- * 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 § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, F.S. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

Name: _____

3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

B. Do you hold, or have you ever held a license to practice in orthotics, prosthetics or pedorthics, or any other health-related license(s)? Yes No

C. List all health-related licenses (active, inactive, or lapsed).

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

Submit a License Verification form to **ALL** state(s) of licensure. License verifications must be received directly from the licensing authority regardless of the status of the license. **A copy of your license will not be accepted** in lieu of official verification from the licensing agency.

D. Have you worked in a job related to orthotics, prosthetics, or pedorthics within the past five years? Yes No

If "Yes," your employer(s) must complete and submit the Verification of Clinical Experience form found at the back of this application.

4. DISASTER

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

5. EDUCATION HISTORY

A. Provide the following information regarding the mandatory board-approved education courses as required in Rule 64B14-5.005, Florida Administrative Code (F.A.C.). If there are any courses you have not completed, visit www.cebroker.com to complete the required course(s). Applicants must submit a certificate of completion to the board for any courses not completed at the time of application submission.

Prevention of Medical Errors Course Title	Provider Name	Date Completed (MM/DD/YYYY)
CPR Certification Course Title	Provider Name	Date Completed (MM/DD/YYYY)
Infection Disease Control Course Title	Provider Name	Date Completed (MM/DD/YYYY)
Florida Laws and Rules Course Title	Provider Name	Date Completed (MM/DD/YYYY)

B. Have you ever been requested to leave, temporarily or permanently, an educational training program prior to the completion of the program? Yes No

If "Yes," you must provide an explanation including all pertinent details such as dates, addresses, physician(s), institution(s), agency(ies), and hospital(s). Additional information may be requested.

Name: _____

Complete the section only for the area in which you are applying.

Orthotist, Prosthetist, or Prosthetist-Orthotist

- A. List in chronological order undergraduate, graduate, and professional education, listing all schools, colleges and universities attended whether completed or not.

School Name	City/State or Country	Dates of Attendance: From-To (MM/DD/YYYY)	Graduation Date (MM/DD/YYYY)	Degree Awarded
		to		
		to		
		to		
		to		

All applicants must have an official transcript forwarded directly to the board office from your educational program. Diplomas and student copies are not acceptable.

If requirements for graduation have been met, but the official graduation ceremony has not been held, the board will accept a letter addressed to the Board of Orthotics and Prosthetics with the registrar's seal from the program director stating that you have met graduation requirements.

- B. If your degree is not in orthotics/prosthetics, you must provide a **certificate of completion** of a training course in orthotics/prosthetics from an institution approved by the Commission on Accreditation of Allied Health Education Programs (CAAHEP).

List the CAAHEP-approved institution you attended for training in orthotics/prosthetics, only if you do not have a degree in orthotics/prosthetics.

Institution Name	City/State or Country	Dates of Attendance: From-To (MM/DD/YYYY)	Graduation Date (MM/DD/YYYY)	Certificate Awarded
		to		
		to		
		to		

Orthotic Fitter, Orthotic Fitter Assistant, or Pedorthist

- A. Have you earned a high school diploma or equivalent? Yes No

- B. Complete the following regarding your high school or equivalent:

School Name	School Address	Graduation Date (MM/DD/YYYY)	Degree Awarded
			Diploma GED
			Diploma GED

Include a copy of your high school diploma or equivalency certificate.

6. TRAINING HISTORY

Complete the section only for the area in which you are applying.

Orthotist, Prosthetist, or Prosthetist-Orthotist

A. Select the method in which you received training in orthotics/prosthetics. Select only one.

Residency Program approved by the National Commission on Orthotic and Prosthetic Education (NCOPE)

1,900-hour internship program

If you completed the NCOPE Residency Program, you must provide an original letter from the head of the residency program attesting to successful completion of the program.

If you completed the 1,900-hour internship program, you must provide a patient log signed by the qualified supervisor, including the types of patients treated, the types of treatment provided, and the number of hours worked, that demonstrates compliance with Rule 64B14-4.100, F.A.C.

B. List all facilities worked in during residency/internship.

Facility Name	City/State	Dates of Attendance: From-To (MM/DD/YYYY)	Hours Completed
		to	
		to	
		to	

Orthotic Fitter or Orthotic Fitter Assistant

A. Have you successfully completed a board-approved orthotics training course administered by Trulife Healthcare or Surgical Appliance Industries? Yes No

B. Complete the following regarding the training course.

Approved Training Course	Dates of Attendance: From-To (MM/DD/YYYY)	Hours Completed
	to	

An original or certified copy of the certificate of completion for the orthotics training course and examination must be submitted to the board directly from the educational program. Diplomas and student copies are not acceptable.

C. Have you successfully completed an approved 8-hour course in casting custom-molded shoes?
Yes No

D. Complete the following regarding the custom-molded shoe course.

Approved Shoe Course	Dates of Attendance: From-To (MM/DD/YYYY)	Hours Completed
	to	

A certificate of completion of the custom-molded shoe course must be submitted to the board directly from the educational program. Diplomas and student copies are not acceptable.

Applicants for **Orthotic Fitter only** must provide **Verification of Clinical Experience form(s) demonstrating two years supervised experience in orthotics** that meets the requirements of Rule 64B14-4.110(1) (b), F.A.C., signed by the applicant's qualified supervisor(s).

Name: _____

Pedorthist

- A. Have you completed a training program of at least 120 hours or an associate degree accredited by the National Commission on Orthotic and Prosthetic Education (NCOPE), as provided in Rule 64B14-4.110(3)(a), F.A.C.? Yes No
- B. Complete the following regarding your training program.

Institution Name	City/State	Dates of Attendance: From-To (MM/DD/YYYY)	Hours Completed
		to	

An original letter from the head of the training course attesting to a minimum of 120 hours of training must be submitted to the board directly from the educational program. Diplomas and student copies are not acceptable.

- C. Have you completed an internship of at least 80 hours of qualified working experience, as determined by the board? Yes No
- D. Complete the following regarding your internship.

Facility Name	City/State	Dates of Attendance: From-To (MM/DD/YYYY)	Hours Completed
		to	
		to	

A patient log signed by the qualified supervisor(s), including the types of patients treated, the types of treatment provided, and the number of hours worked must be submitted.

Applicants who were educated outside the United States must submit the following:

Certified copy of original transcript and seal

Certified translations of any document in a language other than English

Foreign credentials evaluation by board-approved evaluators

All education and training documentation must be submitted directly to the board office at:

Board of Orthotists & Prosthetists
4052 Bald Cypress Way, Bin C-08
Tallahassee, FL 32399-3258

7. EXAMINATION HISTORY

Orthotist, Prosthetist, or Prosthetist-Orthotist only: Have you passed the American Board for Certification (ABC) national certification examination? Yes No

Examination scores must be transmitted to the board office from the ABC. You may contact the ABC at (703) 836-7114 or by email at info@abcop.org.

This information is exempt from public records disclosure.

8. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

- A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? Yes No
- B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? Yes No

Substance-Related Disorders Impacting Ability to Practice

- C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice? Yes No
- D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse? Yes No
- E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse?
Yes No

If a “Yes” response was provided to any of the questions in this section, provide the following documents directly to the board office:

A letter from a Licensed Health Care Practitioner, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

A written self-explanation, identifying the medical condition(s) or occurrence(s); and current status.

Name: _____

9. DISCIPLINE HISTORY

- 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

- 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 ever been named in a malpractice suit or been sued for malpractice? Yes No

- D. 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

- E. To the best of your knowledge, is there any disciplinary action pending against you by any licensing board and/or professional organization? Yes No

If you responded "Yes" to any of the questions in this section complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				Y N
				Y N
				Y N
				Y N

If you responded "Yes" to any of the questions in this section, you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding the disciplinary action.

A copy of the **Administrative Complaint** and **Final Order**.

Name: _____

10. CRIMINAL HISTORY

- A. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld.

Reckless driving, driving while license suspended or revoked (DWSLR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question. Yes No

- B. 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

If you responded “Yes” to any of the questions in this section complete the following:

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				Y N
				Y N
				Y N
				Y N

If you responded “Yes” to any of the questions in this section, you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding each offense; including date, city and state, charges and final results.

Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

Completion of Sentence Documents. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

Name: _____

11. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), F.S.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? Yes No

If you responded "No" to the question above, skip to question 2.

- a. If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? Yes No
 - b. If "Yes" to 1, for the felonies of the third degree, has it been more than ten years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), F.S.)? Yes No
 - c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? Yes No
 - d. If "Yes" to 1, 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," provide supporting documentation)?
Yes No
2. 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 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? Yes No

If you responded "No" to the question above, skip to question 3.

- a. If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? Yes No
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, F.S.?
Yes No

If you responded "No" to the question above, skip to question 4.

- 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

Name: _____

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? Yes No

If you responded "No" to the question above, skip to question 5.

- a. Have you been in good standing with a state Medicaid program for the most recent five years?
Yes No
- b. Did termination occur at least 20 years before the date of this application? Yes No
5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? Yes No
- a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? Yes No
- b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? Yes No

If you responded "Yes" to any of the questions in this section, you must provide the following:

A written self-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.

Supporting documentation including court dispositions or agency orders where applicable.

Documentation for sections 8 and 9 must be sent to the board office at MQA.OrthoPros@flhealth.gov, or mailed to:

Board of Orthotists & Prosthetists
4052 Bald Cypress Way, Bin C-08
Tallahassee, FL 32399-3258

Documentation for section 10 and 11 must be sent to the Background Screening Unit at MQA.BackgroundScreen@flhealth.gov or mailed to:

Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL 32399

Name: _____

12. LIVESCAN PRIVACY STATEMENT

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation (found in the forms following this application).

The board will not receive your Livescan results if you do not confirm the above statement by checking the box.

Electronic Fingerprinting: (Required for ALL applicants)

All applicants, including out-of-state applicants, are required to submit their fingerprints electronically. The Department of Health accepts electronic fingerprinting offered by Livescan service providers that are approved by the Florida Department of Law Enforcement. For a list of approved vendors, visit our website at:

<http://www.flhealthsource.gov/background-screening>.

Typically background results submitted by Livescan are received by the board within 24-72 hours of being processed. The board's ORI number is **EDOH3451Z**. The board cannot accept hard fingerprint cards or results. All results must be submitted electronically by the Livescan service provider.

The Florida Department of Health retains fingerprints on any applicant in the Care Provider Clearinghouse. One of the requirements for your Livescan to be retained in the Care Provider Clearinghouse is a photograph must be taken by the Livescan service provider at the time of fingerprinting.

13. APPLICANT SIGNATURE

The information contained in this application is true and accurate. I hereby authorize all references, education institutions, employers, business and professional organizations and associates, to provide 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 circumstance 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 and I confirm that my answers and all statements made by me herein are true and correct. I understand that if I provide false information that such action shall constitute cause for 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.

Applicant Signature _____ Date _____
You may print this application and sign it or sign digitally. MM/DD/YYYY

An incomplete application shall expire one year after initial filing with the department.

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR ALL APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORDS RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record to be employed, licensed, work under contract, or serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and s. 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Person with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same or similar to yours.

Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of your record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in S. 943.056, F.S., and Rule 11C-8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR ss. 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

PRIVACY STATEMENT

Authority: The FBI's acquisition, preservation and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub. L.92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L.94-29; Pub.L.101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion of approval of your application.

Social Security Account Number (SSAN): Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal Agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint-based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as many be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice, FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosure to: appropriate governmental authorities responsible for civil or criminal law enforcement counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing the application, they may have additional routine uses.

Additional information: The requesting agency and/or the agency conducting the application investigation will provide additional information to the specific circumstances of this application, which may include identification of other authorities, purposes, uses and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice.

Board of Orthotists & Prosthetists

Electronic Fingerprinting



Take this form with you to the Livescan service provider. Check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting a fingerprint scan using the Livescan method.
- You can find Livescan service providers at: <http://www.flhealthsource.gov/background-screening>.
- Failure to submit background screening will delay your application.
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department.
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider, the board office will not receive your background screening results.
- The ORI number for the Board of Orthotists and Prosthetists is **EDOH3451Z**.
- You must provide accurate demographic information to the Livescan service provider at the time your fingerprints are taken, **including your Social Security number (SSN)**.
- Typically background screening results submitted through a Livescan service provider are received by the board within 24-72 hours of being processed.
- If you obtain your Livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name: _____ SSN#: _____
Last First Middle

Aliases: _____

Address: _____ Apt. Number: _____

City: _____ State: _____ ZIP: _____

Date of Birth: _____ Place of Birth: _____
MM/DD/YYYY

Weight: _____ Height: _____ Eye Color: _____ Hair Color: _____

Race: _____
(W-White/Latino(a); B-Black; A-Asian; NA-Native American; U-Unknown)

Sex: _____
(M= Male; F=Female)

Citizenship: _____

Transaction Control Number (TCN#): _____
(This will be provided to you by the Livescan service provider.)

Keep this form for your records.

Complete verifications must be mailed directly from the licensing agency to:

Board of Orthotists & Prosthetists
4052 Bald Cypress Way, Bin C-08
Tallahassee, FL 32399-3258



Board of Orthotists & Prosthetists License Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: _____

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

I hereby authorize release of any information regarding my licensure status to the Florida Board of Orthotists & Prosthetists.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

- * Typed on an official state form or letterhead
- * Include an official board seal
- * Signature and title of state board official

The following information must be included in all verifications:

- * Licensee name
- * License number
- * State or jurisdiction of licensure
- * Licensure status
- * Is license in good standing?
- * Date of issuance/expiration
- * Licensure method (examination, grandfathering, reciprocity/endorsement)
- * Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
- * If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.

Complete verifications must be mailed directly to:

Board of Orthotists & Prosthetists
4052 Bald Cypress Way, Bin C-08
Tallahassee, FL 32399-3258



Board of Orthotists & Prosthetists Verification of Clinical Experience

Part I: To be completed by applicant

Name: _____

Select application type:

Prosthetist-Orthotist (3101)

Prosthetist (3102)

Orthotist (3103)

Orthotic Fitter (3104)

Orthotic Fitter Assistant (3105)

Pedorthist (3106)

Part II: To be completed by employer

Employer Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Telephone Number: _____

Dates of applicant's work experience: From: _____ To: _____
MM/DD/YYYY MM/DD/YYYY

Provide a complete description of job responsibilities as applies to license categories:

Part III: To be completed by supervisor

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

The above information is accurate to the best of my knowledge.

Supervisor Name _____ Florida License Number _____ ABC Certification Number _____

Supervisor Signature _____ Date (MM/DD/YYYY) _____