3062

(6/2015)

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
Email: st-medicine@pa.gov

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110
Medicine – 717-783-1400/717-787-2381

APPLICATION FOR A ORTHOTIC FITTER LICENSE

1.	Submit the $25 fee via check or money order, made payable to the "Commonwealth of Pennsylvania." **FEES ARE NOT REFUNDABLE.** Note: A processing fee of $20 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment. Your cancelled check is your receipt.
2.	If documents will be submitted to the Board under a name different from your present name, submit a copy of the legal document evidencing the name change (i.e., marriage license, divorce decree, naturalization, etc.).
3.	**You may not practice in the Commonwealth of Pennsylvania until the Pennsylvania State Board of has issued your license and you have obtained professional liability insurance.**
4.	The Bureau of Professional and Occupational Affairs (BPOA), in conjunction with the Department of Human Services (DHS), is providing notice to all health-related licensees and funeral directors that are considered "mandatory reporters" under section 6311 of the Child Protective Services Law (CPSL) (23 P.S. § 6311), as amended, that EFFECTIVE JANUARY 1, 2015, all persons applying for issuance of an initial license shall be required to complete 3 hours of DHS-approved training in child abuse recognition and reporting requirements as a condition of licensure. Please review the Board website for further information on approved CE providers. Once you have completed a course, the approved provider will electronically submit your name, date of attendance, etc., to the Board. Child Abuse Continuing Education Providers Information can be found here.

PLEASE NOTE: If a pending application is older than one year from the date submitted and the applicant wishes to continue the application process, the Board shall require the applicant to submit a new application including the required fee. In order to complete the application process, many of the supporting documents associated with the application cannot be more than six months from the date of issuance.

5.	Complete Section 1 of the Verification of Orthotic Fitter Education and forward to your program for completion of Section 2. **The program must return the completed verification directly to the Board. Applicants must demonstrate that they have completed an Orthotic Fitter education program by one of the following methods:**
a.	Provide proof you completed a National Commission on Orthotic and Prosthetic Education (NCOPE) or Board of Certification/Accreditation (BOC) approved education program by having the educational institution submit, directly to the board, the completed Verification of Education Form.
b.	Provide proof of completing an equivalent educational program by requesting the educational program you completed to submit, directly to the board, the completed Verification of Education Form along with an official transcript, course syllabi and/or other information to demonstrate equivalence.
6.	Provide proof of current National certification by contacting The American Board for Certification in Orthotics, Prosthetics & Pedorthics (ABC) or BOC and arrange for your "credential verification" to **be sent directly to the Board**.
7.	Provide proof of completing 1,000 hours of documented orthotic fitting experience. Submit the Verification of Supervised Orthotic Fitter Care Experience to your supervisor, employer or referral source and request that they complete and submit the form, directly to the Board. If more than one employer, supervisor or referral source, please make copies.
8.	Contact the state board office(s) where you hold or have ever held a license, certificate, permit, registration or other authorization to practice a profession or occupation and request letters of good standing. The letter must include the following: license issue and expiration date, license status (current or expired) and disciplinary standing. The letter(s) of good standing must be sent directly to the Board.
9.	Provide proof of professional liability insurance coverage through self-insurance, personally purchased insurance or insurance provided by your employer for the minimum amount of $1,000,000.00 per occurrence or claims made. **This proof of insurance/certificate must include your name and indicate that you are covered under this policy while performing orthotic fitter services in the Commonwealth of Pennsylvania.**
10.	Provide an official notification of information (Self Query) from the National Practitioner Data Bank. Please refer to the NPDB website for additional information. **When you receive the "Response to your Self Query," forward the entire report directly to the Board Office.** You should make a copy for your records.
11.	Attach a current Curriculum Vitae listing **all** periods of employment or unemployment (i.e., child rearing, etc.) from graduation from your orthotic fitter educational program to present. The list must be in chronological order, include the month and year, and indicate the state/territory in which the employment occurred.

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APPLICANT INFORMATION
(Please Print or Type)

NAME:	Last		First		Middle			
ADDRESS:	Street							
City			State		ZIP			
DATE OF BIRTH:	Month	Day	Year	**SOCIAL SECURITY NUMBER:**				
TELEPHONE NUMBER:								
EMAIL ADDRESS:								

If your supporting documents are listed under another name or names, please list below:

Last First Middle

NAME OF ORTHOTIC FITTER EDUCATION PROGRAM:												
ADDRESS OF PROGRAM:												
DATES OF ATTENDANCE:	**FROM**	Month	Day	Year	**TO**	Month	Day	Year	**DATE OF GRADUATION**	Month	Day	Year
TEMPORARY PRACTICE PERMIT - ORTHOTIC FITTER NUMBER:												

LEGAL QUESTIONS

You must answer the following questions. If you answer "YES" to #2 through #12, provide complete details on a separate sheet as well as certified copies of relevant documents.

		Yes	No
1	Do you hold or have you ever held a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction? **If you answered yes, provide the profession and state or jurisdiction.** **LIST**: _____		
2	Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
3	Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?		
4	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
5	Have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		
6	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?		
7	Have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?		
8	Have you had your DEA registration denied, revoked or restricted?		
9	Have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?		
10	Have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		
11	Have you engaged in, the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?		
12	Have you been the subject of a civil malpractice lawsuit? **If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. Submit a statement which includes complete details of the complaints that have been filed against you.** ****If you previously reported the complaint to the Board provide the docket number _____**		

SIGNED STATEMENT

NOTICE: Disclosing your Social Security Number on this application is mandatory in order for the State Boards to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. § 4304.1(a). At the request of the Department of Human Services, the licensing boards must provide to the Department of Human Services information prescribed by the Department of Human Services about the licensee, including the social security number. In addition, Social Security Numbers are required in order for the Board to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa. C.S. Section 4911. I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

_____ _____

Signature of Applicant Date

_____

Printed Name of Applicant

PENNSYLVANIA STATE BOARD OF MEDICINE

VERIFICATION OF ORTHOTIC FITTER EDUCATION

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME:	Last	First	Middle
NAME OF ORTHOTIC FITTER PROGRAM:			
ADDRESS:	City	State	Zip

Submit the verification of education form to your NCOPE (National Commission on Orthotic and Prosthetic Education) accredited orthotic fitter program and request the program return the completed form directly to the board.

SECTION 2 – TO BE COMPLETED BY PROGRAM DIRECTOR OF ORTHOTIC FITTER PROGRAM

NAME OF ORTHOTIC FITTER PROGRAM:						
NAME OF STUDENT:	Last		First		Middle	
DATE STUDENT BEGAN TO ATTEND THIS PROGRAM:			Month	Day	Year	
DATE OF GRADUATION:	Month	Day	Year			

I CERTIFY THAT ALL OF THE INFORMATION LISTED ABOVE IS CORRECT

NAME OF PROGRAM DIRECTOR or REFERRAL SOURCE:	Last	First	Middle	
SIGNATURE:			EIN #:	
DATE:	Month	Day	Year	

(Seal of Program)

Upon completion, program must return this completed form directly to the Pennsylvania State Board of Medicine in an official envelope.

DO NOT RETURN THIS FORM TO THE APPLICANT

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PENNSYLVANIA STATE BOARD OF MEDICINE

VERIFICATION OF SUPERVISED ORTHOTIC FITTING CARE EXPERIENCE

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME OF APPLICANT:	Last	First	Middle

Submit the Verification Of Supervised Orthotic Fitting Care Experience form to your supervisor, employer or referral source to verify that the above-named applicant has completed 1,000 hours of experience providing supervised orthotic fitting services. The employer/supervisor/referral source must complete the form indicating the number of hours they can attest to being performed under their direction/supervision. The employer/supervisor/referral source MUST return the completed form directly to the Board. If more than one employer/supervisor/referral source, make copies of the form and have each employer/supervisor/referral source complete and submit a verification form.

SECTION 2 – TO BE COMPLETED BY A PREVIOUS OR CURRENT EMPLOYER OR SUPERVISOR OR REFERRAL SOURCE QUALIFIED TO VERIFY COMPLETION OF 1,000 HOURS OF SUPERVISED ORTHOTIC FITTING CARE EXPERIENCE. IF ADDITIONAL EMPLOYERS OR SUPERVISORS OR REFERRAL SOURCES THEN USE ADDITIONAL FORMS.

NAME OF EMPLOYER OR SUPERVISOR OR REFERRAL SOURCE:	Last	First	Middle

ADDRESS:	Street		
City		State	ZIP

CERTIFICATION/LICENSE #		PROFESSION:		STATE:	

NUMBER OF HOURS OF SUPERVISED PATIENT FITTING EXPERIENCE THE ABOVE-NAMED INDIVIDUAL COMPLETED UNDER MY SUPERVISION/DIRECTION:	# Hours

I CERTIFY THAT THE INDIVIDUAL REQUESTING LICENSURE AS AN ORTHOTIC FITTER AND LISTED IN SECTION 1 ABOVE HAS COMPLETED THE NUMBER OF HOURS OF EXPERIENCE AS LISTED ABOVE INVOLVING SUPERVISED ORTHOTIC FITTING CARE EXPERIENCE.

SIGNATURE OF EMPLOYER, SUPERVISOR OR REFERRAL SOURCE:		EIN #:

DATE:	Month	Day	Year

Upon completion, please return this completed form directly to the Pennsylvania State Board of Medicine.

DO NOT RETURN THE ORIGINAL FORM TO THE APPLICANT

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