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(6/2015)

Regular Mailing Address	Courier Delivery Address
STATE BOARD OF MEDICINE P.O. BOX 2649 HARRISBURG, PA 17105-2649 Email: st-medicine@pa.gov	STATE BOARD OF MEDICINE 2601 NORTH THIRD STREET HARRISBURG, PA 17110 Medicine – 717-783-1400/717-787-2381

APPLICATION FOR A ORTHOTIST LICENSE

1.	Submit the **$50** 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 Medicine has issued you an Orthotist license and you have obtained professional liability insurance.**

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.

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.
5.	Complete Section 1 of the Verification of Orthotist or Prosthetist/Orthotist Education form and forward to your educational program for completion of Section 2. The Board requires that you have obtained a bachelor's degree, post-baccalaureate certificate or higher degree from a CAAHEP-accredited education program with a major in orthotics or prosthetics/orthotics. **The program must return the completed verification directly to the Board.** **If the Pennsylvania Board of Medicine has granted you a Orthotist Graduate Permit or Orthotist Provisional License, you DO NOT need to have this form completed by the Orthotist or Prosthetist/Orthotist Educational Program.**
6.	**VERIFICATION OF DIRECT PATIENT CARE EXPERIENCE** - Complete Section 1 of the Verification of Direct Care Experience form and forward it to your previous/current employer, supervisor, clinical residency program director or referral source for completion of Section 2. • The form must verify the completion of at least 2 (two) years (3,800 hours) of experience providing direct patient care services in orthotics or prosthetics/orthotics. o **The verification form must be completed by your previous/current employer, supervisor, clinical residency program director or referral source. If verification is completed by a referral source, it must include their Federal EIN (Employer Identification Number).** • If more than one previous/current employer, supervisor, clinical residency program director or referral source, please make copies of the form and distribute, as necessary.
7.	Provide proof that you have met the qualifications and have received certification from the American Board for Certification in Orthotics, Prosthetics & Pedorthics (ABC) or, the Board of Certification/Accreditation (BOC). **The certification must be sent directly to the Pennsylvania Board from credentialing organization**.
8.	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 Orthotist services in the Commonwealth of Pennsylvania.**
9.	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.

10.	Provide an official notification of information (Self Query) from the National Practitioner Data Bank 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 Orthotist or Prosthetist/Orthotist 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 ORTHOTIST OR PROSTHETIST/ ORTHOTIST EDUCATION PROGRAM:												
ADDRESS OF PROGRAM:												
City						State			ZIP			
DATES OF ATTENDANCE:	**FROM**	Month	Day	Year	**TO**	Month	Day	Year	**DATE OF GRADUATION**	Month	Day	Year

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 ORTHOTIST OR PROSTHETIST/ORTHOTIST EDUCATION

If the Pennsylvania Board of Medicine has granted you a Orthotist Graduate Permit or Orthotist Provisional License, you DO NOT need to have this form completed by the Orthotist or Prosthetist/Orthotist Educational Program.

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME:	Last	First	Middle
NAME OF ORTHOTIST OR ORTHOTIST/PROSTHETIST EDUCATION PROGRAM:			
ADDRESS:	City	State	Zip

Submit the verification of medical education form to your Orthotist or Orthotist/Prosthetist program and request the program return the completed form directly to the board.

SECTION 2 – TO BE COMPLETED BY DEAN OR REGISTRAR OF ORTHOTIST OR ORTHOTIST/ PROSTHETIST EDUCATION PROGRAM

NAME OF ORTHOTIST OR ORTHOTIST/PROSTHETIST EDUCATION 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 DEAN/REGISTRAR:	Last	First	Middle
SIGNATURE OF DEAN/REGISTRAR:			
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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VERIFICATION OF TWO YEARS OF DIRECT PATIENTCARE EXPERIENCE

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME OF APPLICANT:	Last	First	Middle

Submit this verification of experience form to your previous/current employer, supervisor, clinical residency program director or referral source to verify that the above-named applicant has completed 2 years (3,800 hours) of experience providing direct patient care services in orthotics or prosthetics/orthotics. The previous/current employer, supervisor, clinical residency program director or referral source must complete the form indicating the number of hours they can attest to being performed under their direction/supervision. They MUST return the completed form directly to the Board. If more than one previous/current employer, supervisor, clinical residency program director or referral source, make a copy of the verification of direct care experience form and have each individual complete and submit a separate verification form. You are required to provide verification of a total of 3,800 hours of direct patient care experience.

SECTION 2 – TO BE COMPLETED BY THE PREVIOUS/CURRENT EMPLOYER, SUPERVISOR, CLINICAL RESIDENCY PROGRAM DIRECTOR OR REFERRAL SOURCE QUALIFIED TO VERIFY COMPLETION OF TWO FULL YEARS (3,800 HOURS) OF DIRECT PATIENT CARE EXPERIENCE.

NAME OF EMPLOYER, SUPERVISOR, CLINICAL RESIDENCY PROGRAM DIRECTOR OR REFERRAL SOURCE:	Last	First	Middle

ADDRESS:	Street		
City		State	ZIP

CERTIFICATION/LICENSE or EIN NUMBER:		PROFESSION:		STATE:	

NUMBER OF HOURS OF DIRECT PATIENT CARE EXPERIENCE THE ABOVE-NAMED INDIVIDUAL COMPLETED UNDER MY SUPERVISION/DIRECTION:	Hours

I CERTIFY THAT THE INDIVIDUAL REQUESTING LICENSURE AS AN ORTHOTIST AND LISTED IN SECTION 1 ABOVE HAS COMPLETED THE NUMBER OF HOURS OF EXPERIENCE AS LISTED ABOVE INVOLVING DIRECT PATIENTCARE EXPERIENCE, INCLUDING PROVIDING DIRECT PATIENT CARE SERVICES IN ORTHOTICS OR PROSTHETICS/ ORTHOTICS.

SIGNATURE OF EMPLOYER, SUPERVISOR, CLINICAL RESIDENCY PROGRAM DIRECTOR OR REFERRAL SOURCE:	
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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