3062

(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 PROSTHETIST PROVISIONAL 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 your Prosthetist Provisional 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.

A Prosthetist Provisional License is valid for a maximum of 2 (two) years and is not renewable.

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 Prosthetist 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 prosthetics or prosthetics/orthotics. **The program must return the completed verification directly to the Board.** **If the Pennsylvania Board of Medicine has granted you an Prosthetist Graduate Permit, you DO NOT need to have this form completed by the Prosthetist or Prosthetist/Orthotist Educational Program.**
6.	Provide proof you have completed a National Commission on Orthotic and Prosthetic Education (NCOPE) accredited prosthetics or prosthetics/orthotics clinical residency program. **The program must send the verification directly to the Board.**
7.	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 Prosthetist services in the Commonwealth of Pennsylvania.
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 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.
10.	Attach a current Curriculum Vitae listing **all** periods of employment or unemployment (i.e., child rearing, etc.) from graduation from your prosthetic or prosthetic/orthotic 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 PROSTHETIST OR PROSTHETIST/ ORTHOTIST EDUCATION PROGRAM:												
ADDRESS OF PROGRAM:												
DATES OF ATTENDANCE:	**FROM**	Month	Day	Year	**TO**	Month	Day	Year	**DATE OF GRADUATION**	Month	Day	Year
PENNSYLVANIA PROSTHETIST GRADUATE PERMIT #: (If applicable)												

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 NCOPE ACCREDITED CLINICAL RESIDENCY

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME:	Last	First	Middle

If training was completed at more than one facility, duplicate this form and submit to each facility.

SECTION 2 – TO BE COMPLETED BY PROGRAM DIRECTOR WHERE THE CLINICAL RESIDENCY OCCURRED

If training was in Pennsylvania, information must coincide with data on Prosthetist Graduate Permit. For applicants still in the second year of training, this form may be completed and signed by the program director thirty (30) days prior to the completion of the approved training. Forms postmarked or signed prior to the 30 (thirty) days will not be accepted.

FACILITY WHERE RESIDENCY WAS COMPLETED:	
ADDRESS:	

CITY	STATE	NCOPE ACCREDITED	
		Yes	No

FROM (MM/DD/YYYY)	TO (MM/DD/YYYY)	

"I certify that the above named applicant successfully completed/will successfully complete this NCOPE accredited clinical residency and that there was/is no disciplinary action outstanding against this applicant. If this applicant does not complete this training, the Board will be notified." If there has been disciplinary or administrative action regarding this applicant, please provide a separate statement outlining the details.

If the facility has no seal or stamp to affix to this document, I will have the form notarized to verify that it was completed by this hospital.

NAME OF CLINICAL RESIDENCY DIRECTOR:	LAST	FIRST	MIDDLE

SIGNATURE OF RESIDENCY DIRECTOR:	

(Seal)	_____ Notary Signature Notary Commission Expiration Date: _____

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PENNSYLVANIA STATE BOARD OF MEDICINE

VERIFICATION OF PROSTHETIST OR PROSTHETIST/ORTHOTIST EDUCATION

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

SECTION 1 – TO BE COMPLETED BY APPLICANT

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

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

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

NAME OF PROSTHETIST OR PROSTHETIST/ORTHOTIST 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

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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