



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

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## APPLICATION INSTRUCTIONS

### Internship/Residency Registration

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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 <http://floridasorthotistsprosthetists.gov/>**

**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
Unlicensed Activity	\$ 5.00
<b>TOTAL FEE</b>	<b>\$505.00</b>

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 - FLORIDA DEPARTMENT OF LAW ENFORCEMENT:**

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD 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 that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 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 Persons 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 as 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 the 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 11C8.001, 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 Sections 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.  
US Department of Justice, Federal Bureau of Investigation,  
Criminal Justice Information Services Division

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, disclosures 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 you additional information pertinent 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.

## 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 is 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.cebroke.com](http://www.cebroke.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.





**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: \_\_\_\_\_  
(Email Notification: If you want to notified of the status of your application by email please check the “YES” box and write your email address on the line provided above. If you choose this form of notification you will receive information regarding your application file through email. You will be responsible for checking your email regularly and updating your email address with the board office [mqa\\_OandP@doh.state.fl.us](mailto:mqa_OandP@doh.state.fl.us) . Under Florida law, email addresses are public records. If you do not want your e-mail 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. [ ] YES [ ] NO

**3. PERSONAL DATA:**

BIRTH DATE: \_\_\_\_\_  
(MM/DD/YYYY)

**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
_____ 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
- d. 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.  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 from 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 from 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



NAME: \_\_\_\_\_

d. 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

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: \_\_\_\_\_ Date Internship/Residency Ends: \_\_\_\_\_  
(MM/DD/YYYY) (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.



## Electronic Fingerprinting

Take this form with you to the Live Scan service provider. Please 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 to a fingerprint scan using the livescan method;
- You can find a Livescan service provider at: <http://www.doh.state.fl.us/mqa/background.html>;
- 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;
- You must provide accurate demographic information to the livescan service provider at the time your fingerprints are taken, **including your Social Security number (SSN)**;
- The ORI number for the Board of Orthotists & Prosthetist is EDOH3451Z;
- 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: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Aliases: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
(MM/DD/YYYY)

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

Sex: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_  
(M=Male; F=Female)

Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Transaction Control Number (TCN#): \_\_\_\_\_

(This will be provided to you by the Live Scan Service provider.)

**Keep this form for your records.**



## 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)



## Mandatory Courses

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

FROM: \_\_\_\_\_  
(Please type or print)

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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)

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