



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

APPLICATION INSTRUCTIONS

Internship/Residency Registration

RENEWAL

Please read these instructions and the laws governing the practice of orthotics and prosthetics before completing your application. To request a renewal of your Internship/Residency Registration, you will be required to submit the renewal application while your registration is still active and valid, but no earlier than one hundred fifty (150) days prior to the expiration of your current Registration. **Failure to receive an approved renewal of your Internship/Residency prior to the expiration date will result in your registration expiring. If your registration expires, you shall cease practicing as a resident in the state of Florida.**

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. INTERN/RESIDENT REGISTRATION RENEWAL:** A registration renewal is permitted only once in each specific residency discipline by statute and is limited to one (1) year (see Section 468.803(3), F.S.). Rule 64B14-4.115, F.A.C. requires that the registration renewal application be received by the Department prior to the expiration of the original registration. The renewal fee shall be that set by Rule 64B14-2.006, F.A.C.
- 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. **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. INTERN/RESIDENT 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 intern/resident from the practice of orthotics, prosthetics, or pedorthics. Furthermore, the Board does not wish to pry into the private affairs of an intern/resident. However, the Board is obligated to determine whether an intern/resident is physically and mentally fit to practice orthotics or prosthetics. 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 intern/resident'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	\$.00
Registration Renewal	\$125.00
Unlicensed Activity	\$ 5.00
TOTAL FEE	\$130.00
- 6. VERIFICATION OF CLINICAL EXPERIENCE:**

Please submit an updated Verification of Clinical Experience form completed by the supervising practitioner.
- 7. ID BADGE:** Please submit legible copies of current ID Badges.

NOTE: Language interpretation services are available to intern/residents 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



**BOARD OF ORTHOTISTS & PROSTHETISTS
INTERNSHIP/RESIDENCY REGISTRATION
RENEWAL**

(PLEASE PRINT OR TYPE IN BLACK INK OR APPLICATION WILL BE RETURNED)

REGISTRATION RENEWAL CATEGORY and NUMBER:

Profession: Orthotist –Client 3109 Prosthetist-Client 3110

Program: Internship Residency

Internship/Residency Registration Number: _____

REGISTRANT 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 . 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

DH-MQA , 7/2013
Rule 64B14-4.115, F.A.C.

NAME: _____

4. SUPERVISOR'S INFORMATION (To be completed by Intern/Resident Supervisor)

_____ (Supervisor's Name)	_____ (Florida License Number)	_____ (ABC Certification Number)
_____ (Name of Practice)	_____ (Practice Telephone Number)	
_____ (Street Address)	_____ (City)	_____ (State) _____ (Zip)

Date Internship/Residency Started: _____ (MM/DD/YYYY) Date Internship/Residency Ends: _____ (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

6. 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

7. STATEMENT OF INTERN/RESIDENT:

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 intern/resident 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 Intern/resident) _____
(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.



VERIFICATION OF CLINICAL EXPERIENCE FORM

This form should be used to document clinical experience and may be duplicated as necessary. Please print or type in black ink.

TO BE COMPLETED BY INTERN/RESIDENT:

NAME: _____
Last First Middle

INTERN/RESIDENT REGISTRATION NUMBER: _____

TO BE COMPLETED BY INTERN/RESIDENT'S SUPERVISING PRACTITIONER:

(only provide information for which you have first-hand knowledge)

- General Information

Employer's Name: _____ Phone Number: _____

Address: _____
(Street and Number or P.O. Box) (City) (State/Province) (Zip/Postal Code)
(Country)

- Work Experience:

Dates of the intern/resident's work experience: _____
(From: Month/Day/Year) (To: Month/Day/Year)

Complete description of job responsibilities:

- Certification by Supervisor:

(Supervisor's Name-PRINT) (Florida License Number) (ABC Certification Number)

The above information is true and correct to the best of my knowledge.

(Signature of Supervisor) (Date)