



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

REGISTRATION SUPERVISOR UPDATE FORM

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. FORM PROCESSING:

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.

2. 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 registration. 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.

RETURN APPLICATION AND SUPPORTING DOCUMENTS TO:

Florida Department of Health
Board of Orthotists and Prosthetists
4052 Bald Cypress Way, Bin #C07
Tallahassee, Florida 32399-3257

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.



DEPARTMENT OF HEALTH
BOARD OF ORTHOTISTS & PROSTHETISTS

REGISTRATION SUPERVISOR UPDATE FORM

CATEGORY:

Profession: [] Orthotist [] Prosthetist

Program: [] Internship [] Residency

PROFILE DATA:

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_optometry@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. REGISTRATION NUMBER:

4. PERSONAL DATA:

BIRTH DATE: (MM/DD/YYYY) BIRTH PLACE: (City) (State/Province) (Country)

NAME: _____

5. APPLICANT REGISTRATION STATUS: (Attach additional sheets if necessary)

Have you received an additional license, certificate, or registration to practice any healthcare profession, in any state, U.S. territory or foreign country since receiving Florida registration?

[] YES [] NO

If yes, please provide the updated 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.)

6. PRACTICE INFORMATION:

CURRENT:

_____	_____	_____
(Supervisor's Name)	(Florida License Number)	(Practice Telephone Number)

_____	_____	_____	_____
(Name of Practice)	(City)	(State)	(Zip)

NEW:

_____	_____
(Supervisor's Name)	(Florida License Number)

_____	_____
(Name of Practice)	(Practice Telephone Number)

_____	_____	_____	_____
(Street Address)	(City)	(State)	(Zip)

Please provide a detailed explanation for changing supervisor: (attach additional pages, if necessary:

NAME: _____

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

(Registrant's Name) (Florida Registration Number)

(Supervisor's Name) (Florida License Number)

(Name of Practice) (Practice Telephone Number)

(Street Address) (City) (State) (Zip)

Date Internship/Residency Starts: _____
Month/Day/Year

Date Internship/Residency Ends: _____
Month/Day/Year

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 reason 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

8. INTERN/RESIDENT 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 Intern/Resident

Date