Complete verifications must be mailed directly to:

Board *of* Orthotists & Prosthetists
4052 Bald Cypress Way, Bin C-08
Tallahassee, FL 32399-3258

Board *of* Orthotists & Prosthetists
Verification of Clinical Experience

Part I: To be completed by applicant

Name: _____

Select application type:

☐ Prosthetist-Orthotist (3101) ☐ Prosthetist (3102) ☐ Orthotist (3103)

☐ Orthotic Fitter (3104) ☐ Orthotic Fitter Assistant (3105) ☐ Pedorthist (3106)

Part II: To be completed by employer

Employer Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Telephone Number: _____

Dates of applicant's work experience: From: _____ To: _____
MM/DD/YYYY MM/DD/YYYY

Provide a complete description of job responsibilities as applies to license categories:

_____

_____

_____

_____

_____

_____

Part III: To be completed by supervisor

(If supervisor is not licensed in Florida, provide ABC Certification Number)

The above information is accurate to the best of my knowledge.

_____
Supervisor Name Florida License Number ABC Certification Number

_____
Supervisor Signature Date (MM/DD/YYYY)