Alabama State Board of Prosthetists and Orthotists
P.O. Box 1052
Montgomery, Alabama 36101
www.apob.alabama.gov
E-mail: rezell113@aol.com
Phone: 334-420-1111

General Application for Licensure

1. **NAME** _____

2. **MAILING ADDRESS** _____

_____

_____

3. **PERMANENT ADDRESS** _____

_____

_____

4. Have you ever been known by any other name? Have you ever changed your name through marriage or court action? YES__ NO __ **If YES, list name, and date of changes below:**

_____

5. Are you a U.S. Citizen? YES ___ NO___ **If no, please attach written proof of applicant's ability to work in the United States as authorized by the U.S. Immigration and Naturalization Board**.

6. **SOCIAL SECURITY NUMBER** _____ 7. **DATE OF BIRTH** (MM/DD/YY) _____

8. **BIRTHPLACE** _____
CITY STATE COUNTRY

9. **HOME TELEPHONE** ( ) _____ 10. **BUSINESS TELEPHONE** ( ) _____

11. **FAX NUMBER** ( ) _____ 12. **E-MAIL ADDRESS** _____

12. **PROFESSIONAL LICENSURE INFORMATION**

Applicant must meet the requirements of the Board of Certification/Accreditation, International; or, the American Board for Certification in Orthotics and Prosthetics. You must attach your certificate to be licensed. Attached ___

12a. Licensure Category. Please **mark** the category you wish to apply for. **Choose one.**

Orthotist ____ Prosthetist _____ Prosthetist/Orthotist _____

Orthotist Assistant _____ Prosthetist Assistant _____ Prosthetist/Orthotist Assistant _____

12b. **Orthotist, Prosthetist, Prosthetist/Orthotist Licensure Pathway**

Applicant must choose **one** of the following:

___ Temporary - For Temporary, please explain your choice on separate paper.
___ Bachelor's Degree in Orthotics and Prosthetics
___ Bachelor's Degree plus a certificate in Orthotics or Prosthetics
___ Associate's Degree including Specific Course Hours
___ Post-Secondary Coursework in Specific Course Hours

12c. **Do you now hold or have you ever held a license or certificate of registration to practice as an orthotist or prosthetist in any state, US Territory, or foreign country?**

No _____

Yes _____ Please list all licenses/registrations below:
Type of License: _____
License #: _____ Issuing Agency: _____
Date of original License/Registration: _____ Expiration Date: _____

If you have had a license which is not current, please attach an explanation on separate sheet of paper

12d. **Have you previously applied for orthotist or prosthetist licensure in Alabama?**

No _____ Yes _____ / Date:_____

13. **Undergraduate and Graduate Education**

(Provide additional sheets if necessary)

Institution	Location	Dates Attended	Major	Degree Earned	Name on Transcript

14. **Clinical Residency or Clinical Laboratory Experience**

(Provide additional sheets if necessary)

Name/Address of Facility	Date Residency Began	Expected Ending Date	Hours Completed	Supervisor's Name	Supervisor's Credentials

15. **EMPLOYMENT**

Beginning with **current** employer, list all prosthetic and orthotic related employment.
Use additional sheets as necessary.

Current Place of Employment: _____
Telephone Number(s): _____
Mailing Address: _____
Date of Employment (from – to): _____

Current Place of Employment: _____
Telephone Number(s): _____
Mailing Address: _____
Date of Employment (from – to): _____

Current Place of Employment: _____
Telephone Number(s): _____
Mailing Address: _____
Date of Employment (from – to): _____

Current Place of Employment: _____
Telephone Number(s): _____
Mailing Address: _____
Date of Employment (from – to): _____

Current Place of Employment: _____
Telephone Number(s): _____
Mailing Address: _____
Date of Employment (from – to): _____

16. **QUESTIONNAIRE**

Answer all of the following questions with either "yes" or "no". Do no leave any blanks.
"Yes" answers **must be accompanied by an Affidavit** (a sworn statement in the presence of a notary public). The affidavit must include all pertinent information such as explanations, dates, addresses, employers, physicians, institutions, agencies, and hospitals.

The Board may request additional information.

a. Have you ever been charged or found guilty of unprofessional or unethical conduct in civil or administrative law proceedings? _____YES _____ NO

b. If you answered "yes" to question a, were the charges settled before or during a formal hearing? _____YES _____ NO

c. Are there any currently pending investigations against you or your company? _____ YES _____ NO

d. Has a licensing, registration, or certification authority taken disciplinary action against you relating to the practice of orthotics or prosthetics, or any health care profession including Medicare/Medicaid fraud? _____ YES _____ NO

e. During the last five years, have you been diagnosed or hospitalized for any physical or mental illness, or injury that would impair your ability to safely practice orthotics or prosthetics: _____ YES _____ NO

f. Have you ever had any professional license or certification denied, probated, suspended, or revoked? _____ YES _____ NO

g. Have you ever practiced with a revoked, suspended, expired, or inactive license? _____ YES _____ NO

h. Have you ever been convicted of any crime excluding minor traffic offenses? _____ YES _____ NO

i. Have you ever been treated for any alcohol or substance abuse? _____ YES _____ NO

17. **STATEMENT AND AFFIDAVIT OF APPLICANT**

I, _____ testify under oath that I am the person referred to in the application and supporting documentation, and that the photograph attached is a photograph of me.

I authorize all my references, educational institutions, employers, hospitals, business or professional organizations and associates, past and present, and all governmental agencies and instrumentalities (local, state, federal) to release to the Alabama Board of Prosthetists and Orthotists any information requested concerning the processing of this application. I understand that it is my duty and responsibility as an applicant to supplement my application when any material changes in circumstances or conditions occur which might affect the Board's decision concerning my eligibility for licensure.

If required by the licensure category under which I applied, I agree to sit for the State examination(s). I also agree that I must pass any required examination(s) to receive my license.

I further agree that if issued a license, upon the revocation, suspension, or cancellation of that license, I shall return the license to the Board.

I understand that I must observe and comply with a code of ethics and standards of practice set forth in the rules, and that I am responsible for keeping the Board informed of my current mailing address at all times. I understand that I am responsible for renewing my license, whether or not I receive a renewal notice.

Under penalties of perjury, I declare and affirm that the statements made in the application, including accompanying statements and transcripts, are true, complete and correct. I understand that providing any false or misleading information in or concerning my application may be cause for denial of loss of licensure.

_____ _____

Signature of Applicant Date Signed

THE STATE OF

COUNTY OF _____

BEFORE ME, the undersigned authority, on this day personally appeared _____ known to me to be the person whose name is subscribed to this instrument, and having been by me first sworn an oath, acknowledged that he or she had executed the same for the purposes and consideration therein expressed and that all statements are true and correct.

GIVEN under my hand and seal of office, this _____day of _____, _____.

Notary Public in and for _____County, _____ State.

_____

Signature of Notary Seal of Notary

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18. **Fee**

Enclose the attached payment remittance and the accurate fee amount.

Mail to: **Alabama State Board of Prosthetists and Orthotists**
P.O. Box 1052
Montgomery AL 36101-1052

Please allow 4 to 5 weeks for processing from the day your application is mailed, even if you mailed it overnight. Incomplete application will not be processed until all required fees and documents are received.

Fee:

Fully complete the form provided below. The Payment Remittance and fees must accompany the application and other required documents to be deemed complete. **The application fee is non-refundable**. Should licensure/registration be denied, full payment of other fees will be refunded.

Schedule of Fees:

Type of License/ Registration Requested	Fee
Non-refundable Application Fee for Licensure	$175
License fee-single discipline	$450
License fee for a single discipline temporary license	$450
License fee for dual/multi discipline	$900
When moving from single to dual	$300
When moving from dual to multi	$0
License duplicate or replacement	$50

Payment Remittance

_____

Name: _____

Social Security #: _____

Address: _____

License/ Registration Applied For:_____

Application Fee: **$**_____

Licensure Fee: **$**_____

Other Fee: **$**_____

Total Amount Enclosed: **$** _____

Alabama State Board of Prosthetists and Orthotists
P.O. 1052
Montgomery AL 36101
334-420-1111

Attestation of Experience Providing Comprehensive Orthotic Care

_____

Name of Applicant (Last, First, Middle) Social Security Number

Comprehensive Orthotic Care must include all the following experiential elements:

Evaluation of patients with a wide range of lower limb, upper limb, and spinal pathomechanical conditions;
Taking measurements and impressions of the involved body segments;
Synthesis of observations and measurements into a custom orthotic design;
Selection of materials and components;
Fabrication of therapeutic or functional orthosis including plastic forming, metal contouring, upholstering, and assembling;
Fitting and critique the orthosis;
Appropriate follow-up, adjustments, modifications and revisions in an orthotic facility;
Instructing patients in the use and care of the orthosis;
Maintaining current encounter notes and patient records.

I attest that I have applied **all** the above listed experiential elements to two-thirds of the orthosis listed in the chart below. (9 of 13) items must be completed in order to qualify).

Orthosis	**Completion Location**	**Completion Date**	**Name & Phone No. of Verification Source** **(Not patient's names)**
Foot			
Knee			
elbow			
ankle-foot			
Cervical			
cervical-thoracic			
cervical-thoracic-lumbarsacral			
thoracic-lumbar-sacral			
lumbar -sacral			
Hip			
wrist-hand			
shoulder-elbow			
shoulder-elbow-wrist-hand			

I have performed comprehensive orthotic care from _____/_____ to _____/ _____

The above information is true and correct. I understand that providing false or misleading information in, with, or concerning my license application maybe cause for denial or loss of licensure. I understand that knowingly providing false information on a government document is punishable by a felony. This form does not constitute application for licensure.

_____

Signature of Applicant Date

Attestation of Experience Providing Comprehensive Prosthetic Care

Name of Applicant (Last, First, Middle) Social Security Number

Comprehensive Prosthetic Care must include **all** the following experiential elements;

Evaluation of patients with a wide range of upper and lower limb deficiencies;
Taking measurements and impressions of the involved body segments, the synthesis of observations and measurements onto a custom prosthetic design;
Selection of materials and components;
Fabrication of functional prostheses including plastic forming, metal contouring, upholstering, assembly, and aligning;
Fitting and critique of the prosthesis;
Appropriate follow-up, adjustments, modifications and revisions in a prosthetic facility;
Instructing patients in the use and care of the prosthesis; and
Maintaining current encounter notes and patient records.

I attest that I have applied all the above listed experiential elements to three fourths of the prostheses listed in the chart below. (6 of 8 items must be completed in order to qualify)

Prosthesis	Completion Location	Completion Date	Name & Phone No. of Verification Source (Not patient's names)
wrist disarticulation			
trans-radial			
knee disarticulation			
trans- humeral			
partial foot			
Symes			
trans- tibial			
trans- femoral			

I have performed comprehensive prosthetic care from _____/_____/_____
The above information is true and correct. I understand that providing false or misleading information in, with or concerning my license application may be cause for denial or loss of licensure. I understand that knowingly providing false information on a government document is punishable by a felony. This form does not constitute application for licensure.

Signature of Applicant Date

8/25/10