

**Alabama State Board of Prosthetists and Orthotists**  
**P.O. Box 1052**  
**Montgomery, Alabama 36101**  
[www.apob.alabama.gov](http://www.apob.alabama.gov)  
E-mail: [rezell113@aol.com](mailto: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

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
License fee for Assistants	\$250
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: \$ \_\_\_\_\_

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## 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-lumbar-sacral			
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 may 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

8/16/12