

Alabama State Board of Prosthetists and Orthotists

Accreditation of Orthotic and/or Prosthetic Facilities

In accordance with The Code of Alabama 1975 § 34-25A-1-14, all facilities where prosthetic, orthotic, or prosthetic and orthotic care is provided to patients needing such care must submit an accreditation application with the Alabama State Board of Prosthetists and Orthotists. This form serves as the official application for accredited facilities. Please complete the following form in full; Forms must be accompanied by application fee and accreditation fee as well as all other required documentation or the form will be returned to the applicant for completion.

Date of Filing: _____

 Name of Facility Owner/Manager of Facility

 E-Mail of Contact Phone Number Fax Number

Main Branch Physical Address:

 Street Address Suite # City State Zip Code

Main Branch Mailing Address:

 Street Address Suite # City State Zip Code

 Compliance Officer Contact Number for Compliance Officer

 (_____ / _____) (_____)

Medicare/ Medicaid Provider Number

NPI

 General liability, malpractice, product liability insurance carrier (**Please include a copy of the insurance certificate with application**)

Is your facility accredited by the Board of Certification/Accreditation, International; or, the American Board for Certification in Orthotics and Prosthetics?

Yes: _____ No: _____ **If yes, please include a copy of accreditation documentation.**

Please list all Satellite Offices (use additional pages if necessary):

Name of Facility	Street Address	City	State	Zip Code
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please list all licensed Orthotists, Prosthetists, Orthotists/Prosthetists, and Assistants practicing in the above facilities (use additional pages if needed). Each office must have a licensed practitioner-in-charge in each discipline for which service is provided to be a supervisor. The practitioner may supervise no more than 2 locations, provided they are no more than 35 miles apart:

Facility Office 1:

Supervisor of Orthotics License Number Supervisor of Prosthetics License Number

Name of Orthotist/Prosthetist License Number Name of Assistant License Number

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Facility Office 2:

Supervisor of Orthotics License Number Supervisor of Prosthetics License Number

Name of Orthotist/Prosthetist License Number Name of Assistant License Number

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Facility Office 3:

Supervisor of Orthotics License Number Supervisor of Prosthetics License Number

Name of Orthotist/Prosthetist License Number Name of Assistant License Number

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Facility Office 4:

Supervisor of Orthotics License Number Supervisor of Prosthetics License Number

Name of Orthotist/Prosthetist License Number Name of Assistant License Number

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Facility Office 5:

Supervisor of Orthotics License Number Supervisor of Prosthetics License Number

Name of Orthotist/Prosthetist License Number Name of Assistant License Number

General Description of Offices:

Total Square feet of office: _____ Number of Patient Fitting/Exam Rooms _____

Number of rooms with parallel bars: _____ Number of chairs in patient waiting area _____

Please list all services provided in your facilities:

Patient Area Description:

Do all patient fitting rooms have doors, screens, or curtains: _____ Yes _____ No

Do patient chairs have arm-rests: _____ Yes _____ No

Do patient fitting rooms contain examination tables with disposable covers or readily disinfected surfaces: _____ Yes _____ No

Are protective gloves and disinfectives suitable for blood-borne and other pathogens available and used in each patient are: _____ Yes _____ No

Are all patient rooms cleaned following each patient visit: _____ Yes _____ No

Laboratory Areas:

All laboratory equipment (machinery) meets OSHA requirements: _____ Yes _____ No

OSHA air quality standards are met: _____ Yes _____ No

Flammable materials are handled and stored according to OSHA and local regulations:
_____ Yes _____ No

Laboratory Areas:

Safety equipment is available and used at all appropriate times: _____ Yes _____ No

The facility has a safety manual and regular scheduled safety training for all employees:
_____ Yes _____ No

I declare the above information is true and correct to the best of my knowledge. 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 state jail felony. This form does not constitute licensure.

Name and Title of Person Signing: _____

Signature

Date

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, _____ or _____

Signature of Notary

Seal of Notary

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 accreditation be denied, full payment of other fees will be refunded.

Schedule of Fees:

Type of Accreditation Requested	Fee
Non-refundable Application Fee for Licensure	\$150
License for Accredited Facilities (for each branch/satellite office)	\$250
License duplicate or replacement	\$50

Payment Remittance

Name: _____

Social Security/ Tax ID #: _____

Address: _____

Number of branch offices (the fee applies to each branch office) _____

Application Fee: _____

Accreditation Fee: _____

Other Fee: _____

Total Amount Enclosed: _____

Alabama State Board of Prosthetists and Orthotists
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