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 are 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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