

# APPLICATION FOR LICENSE IN ORTHOTICS AND/OR PROSTHETICS



**State Board of Orthotics, Prosthetics and Pedorthics**  
**77 S. High Street, 18th Floor**  
**Columbus, Ohio 43215**  
**614.466.1157**  
[www.opp.ohio.gov](http://www.opp.ohio.gov)

**INSTRUCTIONS:** Completion and submission of this form, by hard copy or electronically, is required for an individual applying for an initial license to practice Pedorthics in the state of Ohio. Please complete all sections and include all requested documentation and applicable fees. If a section does not apply, please mark N/A. **NOTE:** All information must be entered by typeface or printing in **INK**. When fully completed, the application form must be **NOTARIZED**. All fees that are not payable online must be submitted in the form of a **MONEY ORDER** or **BANK CHECK** or **BUSINESS CHECK** and made payable to the **TREASURER, STATE OF OHIO. All initial application fees are non-refundable.** A **2" x 2" PHOTO** of applicant (passport-type photo of face) must accompany application.

**DISCLOSURES:** Information requested on this form is required for orderly administrative processes and to document or determine qualifications for licensure under Ohio Revised Code Sections 4779.09, 4779.10, 4779.11, 4779.12, 4779.17 and/or 4779.18. Information provided on this form may be subject to disclosure under Ohio Public Records laws, subject to the Board's responsibility to maintain and in certain cases protect from re-disclosure Confidential Personal Information (CPI) such as SSN's. The Board's Administrative Rule series governing use of and access to CPI is at OAC Agency Rule Series 4779-13. **BY SUBMITTING THIS APPLICATION, YOU ARE ACKNOWLEDGING THAT YOU UNDERSTAND BOARD PERSONNEL MAY ACCESS YOUR INFORMATION IN THE COURSE OF PROCESSING THE APPLICATION AND/OR RESPONDING TO ANY LAWFUL INQUIRIES IN THIS REGARD.**

**Part A - Personal Information**

1. First Name		Middle Name	Last Name		
2. As an adult, have you been known by any other names? If YES, please provide full prior names/aliases:		<input type="checkbox"/> Yes / <input type="checkbox"/> No	First Name	Middle Name	Last Name
3. Residential Mailing Address: County		Street	City	State	Zip Code
4. Social Security Number (required*) - -		5. Date of Birth (mm/dd/yy) / /		6. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
7. Home Telephone Number ( ) -		8. Mobile Telephone Number ( ) -		9. Personal Email Address	

\* Provision of your social security number ("SSN") is mandatory for child support purposes, pursuant to Ohio Revised Code Section 3123.50. Provision of your SSN will also facilitate the processing of your application. Your social security number may also be disclosed to the Federal Department of Health and Human Services' National Practitioner Data Bank (NPDB), pursuant to Title IV, of Public Law 99-660, the Healthcare Quality Improvement Act of 1986, as amended; 45 CFR pt. 60 and 61; Section 1921 of the Social Security Act; and Section 1128E of the Social Security Act, as amended by Section 221(a) of the Health Insurance Portability and Accountability Act of 1996. It may also be used for reporting to law enforcement authorities for investigative/law enforcement purposes in compliance with ORC 4761.031, and/or as otherwise required by state and federal law. Your social security number is protected from redisclosure under Ohio law as confidential personal information.

FOR OFFICE USE ONLY
Application Received:
Amount \$:
Money Order#:
Batch Number:
Original Issue Date:
License Number:

**TAPE Passport Photo Here**

Photograph must be 2 x 2 inches in size, full face, front view, between 1 inch and 1 3/8 inches from the bottom of the chin to the top of the head. Background color white, off-white, or light blue. Photograph must be taken within the past 6 months. Sign back of photograph.

(Print Name)

**Part B - Current Business Address**

Present Employer				
Street Address	City	State	Zip Code	County
Position Title		Dates of Employment		
Supervisor's Name	Telephone Number ( ) -	Applicant's Work Email Address		

Preferred Credential Mailing Address:  Home /  Business

**Part C - Authorization Requested & Fees: (fees are set by Administrative Rule, see OAC Rule 4779-12-01)**

Please check only one

<input type="checkbox"/>	Temporary License - Orthotics**	\$150.00	Full licenses expire on the 31st of January of the year after issue. Licenses issued in December will renew in January for a reduced fee. Temporary licenses expire one year after issue and can only be renewed once.
<input type="checkbox"/>	Temporary License - Prosthetics**	\$150.00	
<input type="checkbox"/>	Temporary License - P&O**	\$150.00	
<input type="checkbox"/>	Full License - Orthotics	\$150.00	
<input type="checkbox"/>	Full License - Prosthetics	\$150.00	
<input type="checkbox"/>	Full License - Prosthetics & Orthotics	\$150.00	
<input type="checkbox"/>	Limited Reciprocity Pathway *	\$150.00	

\* If Limited Reciprocity, please choose one :  Orthotics  Prosthetics  Prosthetics & Orthotics

\*\*Choose Temporary if your residency was not in state and you do not have at least 8 months of in-state supervised work experience, and/or if you have not yet passed the ABC profession-specific written and written simulation exams.

**Part D - Educational History (include a copy of diplomas, degrees or certificates earned):**

Name of College or University	City	State	Certificate / Degree	Dates Attended (MM/YY) From To
Name on transcript (if different)				
Other Post High School Institution	City	State	Certificate / Degree	Dates Attended (MM/YY) From To
Other Post High School Institution	City	State	Certificate / Degree	Dates Attended (MM/YY) From To

Did you complete a post-graduate Certificate program in Prosthetics?  Yes (include cert.) /  No  Degree is in O&P

Did you complete an post-graduate Certificate program in Orthotics?  Yes (include cert.) /  No  Degree is in O&P

**Part E - Clinical Residency (include Certificate of Completion or other documentation of a Residency meeting NCOPE standards):**

Name of Facility			
Street Address	City	State	Zip Code
Name & Credentials of Supervisor	Hours Completed	Start Date	End Date

\_\_\_\_\_(Print Name)

**Part F - Practice Information & Supervision**

- 1. Do you have experience other than in coursework or residency practicing the principles or procedures in the fields of Prosthetics or Orthotics?  
 Yes  No
- 2. Has any of your practical experience been under the supervision of an Ohio-Licensed Practitioner?  
 Yes  No

« If yes, please list the name(s) of the Licensed Practitioner(s), including license type and number:

Name	Dates of Supervision (MM/YY)		License #
	From	To	
Name	Dates of Supervision (MM/YY)		License #
	From	To	

- 3. Are you currently certified in prosthetics and/or orthotics from the American Board of Certification in Orthotics and Prosthetics? (If yes, please attach copy of certificate.)  
 Yes  No      If yes, by exam?  Yes  No      Date of Exam: \_\_\_\_\_

- include copy of score report if available

**Part G - Licensure History**

- 1. Do you possess a license, certification, or registration in any profession issued by this state or any other state?  
 Yes  No

« If yes, please complete:

License #	Type	Date Issued	State
		/ /	
License #	Type	Date Issued	State
		/ /	

\*Only report government-issued license certifications or registrations in this space.

**Part H - Required Questions\***

(Boxes must be INITIALED, not checked)

Answer ALL of the following questions. DO NOT LEAVE ANY QUESTION BLANK.		YES	NO
1.	Have you been convicted, had a judicial finding of guilt, pled no contest or entered a plea of guilty to a violation of federal or state law or municipal ordinance other than a minor traffic violation, whether in this state or any other state? (DUI/DWI is NOT a minor offense.)		
2.	Have you been denied licensure, certification, or registration for any reason in this state or any other state?		
3.	Has any license entitling you to practice in any state been revoked, suspended, or voluntarily surrendered?		
4.	Have you ever practiced with a revoked, suspended, expired, or inactive license?		
5.	Have you entered into an agreement of any kind with respect to a professional license, whether oral or written, in lieu of formal disciplinary action with any board, bureau department, agency, or other licensing or certifying body whether in this state or any other state?		
6.	Have you been notified of any charges or complaints filed against you with respect to Medicare/Medicaid fraud in this state or any other state?		
7.	Have you had any administrative, civil, or criminal action filed against you with respect to Medicare/Medicaid fraud in this state or any other state?		
8.	Are you currently engaged in the illegal use of controlled or dangerous substances, or are you currently engaging in the use of alcohol to the extent that it impairs your practice in the field of orthotics and/or prosthetics?		
9.	Are you currently participating in a supervised rehabilitation program or professional assistance program that includes monitoring to assure that you are not engaging in the use of controlled or dangerous substances?		



\_\_\_\_\_(Print Name)

**Part I - Affidavit of Applicant**

I, \_\_\_\_\_ (Full Legal Name), testify under oath that I am the person referred to in the application and supporting documentation, and that the photograph attached to the application is a photograph of

I authorize all my references, educational institutions, employers, hospitals, business and professional organizations and associates -past and present - and all government agencies and instrumentalities (local, state, federal) to release to the State Board of Orthotics, Prosthetics, & Pedorthics any information requested for 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.

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 certify that I have received a copy of or have been provided access to Chapter 4779 of the Ohio Revised Code and rules concerning the regulation of Orthotics, Prosthetics, and Pedorthics in the State of Ohio. I understand that I must observe and comply with the 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 penalty of falsification, 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 false or misleading information in or concerning my application may be cause for denial or loss of licensure, and criminal prosecution.

\_\_\_\_\_  
Signature of Applicant (to be signed before Notary Public only)

\_\_\_\_\_  
Date Signed

THE STATE OF                }  
COUNTY OF                }

Sworn to and subscribed before me, a Notary Public and, in my presence, the

said \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public

**Enclosed: Non-refundable application fee per applicant (see Part C for fees) by Money Order, Bank Check or Business Check made payable to "Treasurer, State of Ohio", completed application, and photo.**

**Mail To:**                               **State Board of Orthotics, Prosthetics & Pedorthics**  
  **Riffe Center, 18th Floor**  
  **77 South High Street**  
  **Columbus, Ohio 43215**

*Note: Please allow 3 to 4 weeks for processing from the date your application is received. An incomplete application will not be processed until all required documents and fees are received.*

**DO NOT WRITE BELOW THIS LINE - FOR OPP USE ONLY**

<b>Criminal Background Checks Receipt</b>	<b>Received</b>	<b>Receipt Date</b>
Ohio Civilian Background Check	<input type="checkbox"/> Yes / <input type="checkbox"/> No	
FBI Background Check	<input type="checkbox"/> Yes / <input type="checkbox"/> No	

\_\_\_\_\_(Print Name)

**Applicants for a Temporary License in Orthotics and/or Prosthetics must also complete the following section.**

**Part J - Supervision Statement for Orthotic and/or Prosthetic Practice**

(Ref: OAC Rule 4779-5-03)

This statement is being submitted for the purpose of (choose one):

- Confirming an arrangement / agreement is in place for Temporary License supervision that will be appropriate to meet the requirements of ORC Section 4779.18 and OAC Rule 4779-6-01
- Attesting to completion of supervision in accordance with and meeting the requirements of ORC Section 4779.10, 4779.11, 4779.12; and OAC Rule 4779-6-01 (Temporary License Application Procedure) or as required by OAC Rule 4779-5-03 (License Application Procedure)

**By our signatures below (supervisor and supervisee), we confirm that we**

**will in engage in**      **OR**       **have engaged in**

**a supervisory relationship consistent with the requirements of ORC § 4779.18 (B) [Temporary License]; or a supervisory relationship consistent with the requirements of ORC § 4779.10 (A)(1) [Orthotics]; § 4779.11 (A)(1) [Prosthetics]; or § 4779.12 (A)(1) [Prosthetics and Orthotics].**

Supervisor:

Signature of Supervisor	Date	License #	Printed Name of Supervisor

Supervisee:

Signature of Supervisee	Date	License #	Printed Name of Supervisee

Supervision begin date: \_\_\_\_\_ Supervision complete date: \_\_\_\_\_