

**THE STATE BOARD OF ORTHOTICS, PROSTHETICS AND PEDORTHICS**  
**77 SOUTH HIGH STREET, 18<sup>TH</sup> FLOOR**      **COLUMBUS, OHIO 43215**  
**TEL: (614) 466-1157**      **FAX: 614) 387-7347**

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WHEN APPLYING FOR A LICENSE IN **PROSTHETICS AND ORTHOTICS**, PLEASE  
REFERENCE THE FOLLOWING CHECK-LIST WHEN COMPLETING YOUR APPLICATION:

**TEMPORARY LICENSE:**

**ORC § 4779.18 (A) (4) (c)**

- Fee: \$150 by Cashier/Bank check or Money Order payable to Treasurer, State of Ohio
- Document: Proof of highest post-secondary educational credential (Bachelors or better)
- Document: Certificate of Completion of Post-graduate Certificate Program in Prosthetics (exception: Bachelors or Masters in Orthotics & Prosthetics)
- Document: a. Completion of Residency Program(s) in Prosthetics and Orthotics  
b. Statement from Supervisor/Applicant stating compliance with law/rules governing supervision (see summary [here](#))
- Document: Proof of submission of fingerprints for criminal record checks by Ohio BCI&I and F.B.I. (copy of payment receipt, or statement confirming submission)

**FULL LICENSE:**

**ORC § 4779.12 (A)**

- Fee: \$125 by Cashier/Bank check or Money Order payable to Treasurer, State of Ohio
- Document: Proof of highest post-secondary educational credential (Bachelors or better)
- Document: Certificate of Completion of Post-graduate Certificate Program in Prosthetics (exception: Bachelors or Masters in Orthotics & Prosthetics)
- Document: Completion of Residency programs in Orthotics & Prosthetics consisting of 1900 hours (each profession) supervised by practitioner certified in profession.
- Document: Letter/statement from Ohio-licensed practitioner, attesting to having conducted supervision for minimum 8-month period under law and rules governing supervision (required if Residency not conducted under Ohio-licensed supervisee).
- Document: Proof of submission of fingerprints for criminal record checks by Ohio BCI&I and F.B.I. (required for issuance of initial license only).

**LIMITED RECIPROCITY:**

**ORC § 4779.17 (A), (B), & (C) (3)**

- Fee: \$125 by Cashier/Bank check or Money Order payable to Treasurer, State of Ohio
- Document: Proof of highest post-secondary educational credential (Bachelors or better)
- Document: Certificate of Completion of Post-graduate Certificate Program in Prosthetics (exception: Bachelors or Masters in Orthotics & Prosthetics)
- Document: Completion of Residency program in Prosthetics consisting of 1900 hours supervised by practitioner certified in Prosthetics.
- Document: Proof of active license in good standing issued by "the appropriate authority of another state."
- Document: Proof of submission of fingerprints for criminal record checks by Ohio BCI&I and F.B.I. (required for issuance of initial license only).

# APPLICATION FOR LICENSURE : PROSTHETICS-ORTHOTICS

STATE BOARD OF ORTHOTICS, PROSTHETICS AND PEDORTHICS (OHIO)

## IMPORTANT INSTRUCTIONS, PLEASE READ:

- ▶ Complete all relevant categories (type or print in INK).
- ▶ Application form must be **NOTARIZED**.
- ▶ The following must accompany the application form:
  - 2" x 2" photo of applicant, passport type photo of face.
  - Non-refundable \$125.00 application fee, per applicant (**Money order/ Cashier's check** payable to "**Treasurer, State of Ohio**").
  - **Fee is \$150 for a Temporary License**

**Tape one  
2" x 2"  
Current Photo of  
Applicant**

## PERSONAL INFORMATION:

**NAME** \_\_\_\_\_  
(FIRST) (MIDDLE INITIAL) (LAST)

**RESIDENTIAL ADDRESS** \_\_\_\_\_

**BUSINESS ADDRESS** \_\_\_\_\_

**HOME PHONE** ( ) \_\_\_\_\_ **BUSINESS PHONE** ( ) \_\_\_\_\_

**FAX NUMBER** ( ) \_\_\_\_\_ **CELL PHONE** ( ) \_\_\_\_\_

**E-MAIL ADDRESS** \_\_\_\_\_

Have you ever been known by any other name?  Yes  No

If so, please state other names you were known by: \_\_\_\_\_

**SOCIAL SECURITY NUMBER\*** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_/\_\_\_\_/\_\_\_\_

\*Social Security Numbers are required of all licensees pursuant to 42 U.S.C. §1329a-7e(b), 5 U.S.C. §552a, and 45 C.F.R. pr.61, and Ohio Revised Code §3123.50 for potential disclosure to the Federal Department of Health and Human Services Healthcare Integrity and Protection Data Bank and/or the Local County Child Support Enforcement Agency. In compliance with the revised Code §1347.05 (E) you are notified that failure to supply the information requested on this application may result in a denial of the application. SSN's are NOT subject to public record disclosure by this agency.

### FOR OFFICE USE ONLY

**APPLICATION RECEIVED:** \_\_\_\_\_ **AMOUNT:** \_\_\_\_\_ **MONEY ORDER#** \_\_\_\_\_

**ORIGINAL ISSUE DATE:** \_\_\_\_\_ **LICENSE NUMBER:** \_\_\_\_\_

## EDUCATIONAL INFORMATION: (complete all that apply)

### HIGH SCHOOL:

Name of Institution \_\_\_\_\_

Location (City,State) \_\_\_\_\_ Date Graduated \_\_\_\_\_

### COLLEGE EDUCATION: (include a copy of your diploma)

Name of Institution \_\_\_\_\_

Location (City, State) \_\_\_\_\_

Dates Attended \_\_\_\_\_ Degree Earned \_\_\_\_\_

Name on Transcript \_\_\_\_\_

Did you complete a Certificate program in Prosthetics?  Yes  No

Did you complete a Certificate program in Orthotics?  Yes  No

➤ If yes, please attach documentation

### CLINICAL RESIDENCY: (provide additional sheets if necessary)

Name of Facility \_\_\_\_\_

Address of Facility \_\_\_\_\_

Date Residency Began \_\_\_\_\_ Ending Date \_\_\_\_\_

Hours Completed \_\_\_\_\_ Name & Credentials of Supervisor \_\_\_\_\_

## PRACTICE INFORMATION:

Have you practiced the principles or procedures in the field of prosthetics and orthotics, including but not limited to the evaluation, measurement, design, assembly, fitting, adjusting, servicing, or training in the use of a prosthetic, orthotic and/or pedorthic device, or the repair, replacement, adjustment, or service of an existing device?  Yes  No

Has any of your practical experience been under the supervision of a Licensed Prosthetist/Orthotist?

Yes  No

➤ If yes, please list the name(s) of the Licensed Person (including his/her license number) you have been supervised by: (provide additional sheets if necessary)

Name \_\_\_\_\_ Dates of Supervision \_\_\_\_\_ License # \_\_\_\_\_ State: \_\_\_\_\_

Name \_\_\_\_\_ Dates of Supervision \_\_\_\_\_ License# \_\_\_\_\_ State: \_\_\_\_\_

Are you currently certified in prosthetics-orthotics from either the American Board of Certification in Orthotics and Prosthetics or Board for Orthotist/Prosthetist Certification?  Yes  No

➤ If yes, please attach a copy of the certificate

APPLICATION FOR LICENSURE : PROSTHETICS-ORTHOTICS

STATE BOARD OF ORTHOTICS, PROSTHETICS AND PEDORTHICS (OHIO)

**QUESTIONNAIRE: Answer ALL of the following questions with either "YES" or "NO". DO NOT LEAVE ANY QUESTION BLANK. NOTE: An attached written AFFIDAVIT (a sworn statement in the presence of a notary public) must accompany any "YES" answers (to questions 1-10) explaining in detail the "YES" answer. The affidavit must include all pertinent information such as explanations, dates, addresses, employers, physicians, institutions, agencies, and hospitals. Additional information may be requested by the Board, such as documents, employment verification, evaluation letters from treating physicians, etc.**

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, 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)  
 Yes  No
2. Have you been denied licensure, certification, or registration for any reason in this state or any other state?  
 Yes  No
3. Has any license entitling you to practice in any state been revoked, suspended, or voluntarily surrendered?  
 Yes  No
4. Have you ever practiced with a revoked, suspended, expired, or inactive license?  
 Yes  No
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?  
 Yes  No
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?  
 Yes  No
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?  
 Yes  No
8. Are you currently engaged in the illegal use of controlled or dangerous substances?  
 Yes  No
9. Are you currently participating in a supervised rehabilitation program or professional assistance program that includes monitoring to assure that you are not illegally engaging in the use of controlled or dangerous substances?  
 Yes  No
10. Are you currently engaging in the use of alcohol to the extent that it impairs your practice in the field of prosthetics?  
 Yes  No
11. 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: \_\_\_\_\_

## ATTESTATION OF PRACTICE OR TEACHING PROSTHETIC CARE

**Prosthetic care must include all of 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 prosthetic design;**
- **Selection of materials and components;**
- **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 prostheses; and**
- **Maintaining current patient records.**

*I attest that I have completed substantially all the above listed elements to the Prosthetic device as indicated below. Please put a check mark in the appropriate box, and include the facility of practice and supervisors name in the completed box.*

<b>Prostheses</b>	<b>Completed (List Facility and Supervisor)</b>	<b>Not Completed</b>
Wrist disarticulation		
Trans radial		
Trans humeral		
Shoulder disarticulation		
Partial foot		
Symes		
Trans tibial		
Trans femoral		
Hip disarticulation		

The above information is true and correct. I understand that providing false or misleading information in, with, or concerning my license may be cause for denial or loss of license. I understand that knowingly providing false information on a government document is punishable as a first degree misdemeanor, pursuant to R.C. 2921.13.

## ATTESTATION OF PRACTICE OR TEACHING ORTHOTIC CARE

➤ **Orthotic care must include all of 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;**
- **Fitting and critique of the orthosis;**
- **Appropriate follow-up, adjustments, modifications and revisions in a orthotic facility;**
- **Instructing patients in the use and care of the orthosis; and**
- **Maintaining current patient records.**

*I attest that I have completed substantially all the above listed elements to the Orthotic device as indicated below. Please put a check mark in the appropriate box, and include the facility of practice and supervisors name in the completed box.*

<b>Orthosis</b>	<b>Procedure Completed (List Facility and Supervisor)</b>	<b>Not Completed</b>
Foot		
Ankle-foot		
Knee-ankle-foot		
Hip-knee-ankle-foot		
Hip		
Knee		
Cervical		
Cervical-thoracic		
Thoracic-lumbar-sacral		
Lumbar-sacral		
Cervical-thoracic-lumbar-sacral		
Hand		

The above information is true and correct. I understand that providing false or misleading information in, with, or concerning my license may be cause for denial or loss of license. I understand that knowingly providing false information on a government document is punishable as a first degree misdemeanor, pursuant to R.C. 2921.13

# 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 to the application is a photograph of me.

I authorize all my references, education institutions, employers, hospitals, business and professional organizations and associates, past present, and all governmental agencies and instrumentalities (local, state, federal), to release to the State Board of Orthotics, Prosthetics, & Pedorthics and 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.

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 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

\_\_\_\_\_  
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:** The non-refundable \$125.00 application fee (\$150 for a Temporary License), completed application and photo.

**MAIL TO** Make Cashier's check payable to "Treasurer, State of Ohio"  
State Board of Orthotics Prosthetics, and Pedorthics  
Riffe Center, 18<sup>th</sup> 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 fees and documents are received. For current information, check online at:*

<http://opp.ohio.gov>