APPLICATION FOR LICENSURE FOR PROSTHETIST ACTIVELY PRACTICING OR TEACHING PROSTHETICS AS OF OCTOBER 27, 2000* OHIO STATE BOARD OF ORTHOTICS, PROSTHETICS, AND PEDORTHICS

(commonly referred to as "grandfathering")

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**".

Tape one 2" x 2" Current Photo of Applicant

PERSONAL INFORMATION:

NAME____

(FIRST) (MIDDLE INITIAL) (LAST)

MAILING ADDRESS____

____

PERMANENT ADDRESS____

____

HOME PHONE (   )____________________ **BUSINESS PHONE (   )**____________

FAX NUMBER (   )____________________ **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 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.**

- **FOR OFFICE USE ONLY:**

APPLICATION RECEIVED:____________ **AMOUNT:**__________ **MONEY ORDER#** ____________

ORIGINAL ISSUE DATE:______________**LICENSE NUMBER:**________________________

PROFESSIONAL INFORMATION:

Undergraduate and Graduate Education. (Provide additional sheets if necessary).

Name of Institution____

Location____

Dates Attended________________________________**Degree Earned**____________________________

Name on Transcript____

Clinical Residency or Clinical Laboratory experience. (Provide additional sheets if necessary).

Name of Facility____

Address of Facility____

Date Residency Began_____________________________ **Ending Date**_________________________

Hours Completed_________________**Name & Credentials of Supervisor**__________________________

PRACTICE OR TEACHING INFORMATION

1. Were you practicing on or before October 27, 2000, any of the principles or procedures in the field of prosthetics including but not limited to the evaluation, measurement, design, assembly, fitting, adjusting, servicing, or training in the use of a prosthetic or pedorthic device, or the repair, replacement, adjustment, or service of an existing prosthetic or pedorthic device? ❑ **Yes** ❑ **No**

If so, please identify the public or private entity where you have practiced the field of Prosthetics:

Name____

Address____

Phone Number____

- **Please attach at least one document reflecting proof of employment, including but not limited to professional listings, advertisements, pay stubs, or a professional reference.**

2. Were you teaching on or before October 27, 2000 in the field of prosthetics the following principles or procedures: the evaluation, measurement, design, fabrication, assembly, fitting, adjusting, servicing, or training in the use of a prosthetic or pedorthic device, or the repair, replacement, adjustment, or service of an existing prosthetic or pedorthic device? ❑**Yes** ❑**No**

If so, please identify the public or private entity where you taught:

Name____
Address____
Phone Number____

- **Please attach at least one document reflecting proof of, but not limited to, course listings, published professional articles, or a professional reference.**

☛ **If you have answered Yes to EITHER question 1 or 2, please complete the following of EITHER Option A or Option B below:**

OPTION A.

Did you receive a degree from a nationally-accredited college or university?

❑ Yes ❑ No

- **If so, please attach a copy of the diploma showing receipt of a bachelor or higher degree from a nationally accredited college or university in the United States.**

Did you receive a certificate from either the American Board of Certification in Orthotics and Prosthetics or Board for Orthotist/Prosthetist Certification?

❑ Yes ❑ No

Have you completed a residency period requiring 1,900 hours under the direct supervision of a Certified Prosthetist? ❑Yes ❑No

- **If so, please attach a copy of the certificate or a written statement from the supervising Certified Prosthetist demonstrating successful completion of the program.**

OR COMPLETE . . .

OPTION B.

Have you been actively practicing or teaching prosthetics full-time since October, 1997?
"Full-time" means, not less than 1600 hours per year (R.C. 4779.01(B).

❑Yes ❑No

Have you passed the certification examination in prosthetics from either the American Board of Certification in Orthotics and Prosthetics or Board for Orthotist/Prosthetist Certification?

❑Yes ❑No

- **If so, please attach a copy of the certificate demonstrating successful completion of the examination.**

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 of 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 an prosthetic facility;**
- **Instructing patients in the use and care if the prostheses; and**
- **Maintaining current patient records.**

I attest that during the period of October 27, 1999 thru October 27, 2000 I completed all the above listed elements to the prosthesess 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.

Prostheses	Completed (List Facility and Supervisor)	Not Completed
Wrist disarticulation		
Trans radial		
Trans humeral		
Shoulder disarticulation		
Partial foot		
Symes		
Below knee trans tibial		
Above knee 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.

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 instumentalities (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__________, 2001

____

Notary Public

ENCLOSED: The non-refundable $125.00 application fee, per applicant completed application and photo.
Make Cashier's check payable to "Treasurer, State of Ohio"
MAIL TO State Board of Orthotics Protsthetics, and Pedorthics
Riffe Center, 16th 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.