



Certified Orthotic Fitter Application

| Personal Information | | | |
|---|---|---|---|
| First Name | Last Name | Middle Initial | Gender <input type="checkbox"/> M <input type="checkbox"/> F |
| Home Street Address | | Apartment Number | |
| City | State/Province | Zip/Postal Code | Country |
| Email Address | Telephone Number (include area code) | | Mobile Number (include area code) |
| Date of Birth (mm/dd/yyyy) | Social Security Number / Canadian Health Number | | Preferred Mailing Address <input type="checkbox"/> Home <input type="checkbox"/> Work |
| <input type="checkbox"/> Please exclude my contact information from distribution to third parties. | | | |
| Professional Information | | | |
| Education Level (check highest level completed, and fill in the year of completion) | | | |
| <input type="checkbox"/> High School | Year: _____ | <input type="checkbox"/> Baccalaureate | Year: _____ |
| <input type="checkbox"/> Associate Degree | Year: _____ | <input type="checkbox"/> Post Baccalaureate | Year: _____ |
| Current Professional Credentials (examples: BOCO, BOCP, CMF, etc.) | | | |
| Company Name (your employer) | | Name of Immediate Supervisor | |
| Office Street | | Suite Number | |
| City | State/Province | Zip/Postal Code | Country |
| Telephone Number (include area code) | Fax Number (include area code) | | Is this an accredited facility? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure |
| Patient Care and Experience Requirement | | | |
| I have a minimum of 1000 hours (approximately 25 weeks of full-time work) of documented patient care. Please keep patient logs or a notarized letter of attestation from your supervisor readily available. | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| I have included a copy of the certificate of attendance from a BOC-approved orthotic fitter entry-level course. | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Questionnaire | | | |
| Have you been named as a defendant in a professional liability suit during the past five years? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any professional practice judgments or settlements against you in the past five years? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has your professional certification/license ever been affected negatively by any agency? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever been convicted of one or more felonies? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has Medicaid or any other medical plan ever brought charges against you for any reason? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has your professional liability coverage ever been restricted, limited, denied, or denied renewal? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If you answered "Yes" to any of the above, please enclose an explanation on a separate sheet. | | | |



| Attestation | | |
|---|---------------------------------|--|
| I attest that the information reported on this application, and in all accompanying documentation is true and accurate to the best of my knowledge. | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Exam Month (Please Choose One) | | |
| <input type="checkbox"/> January | <input type="checkbox"/> May | <input type="checkbox"/> September |
| <input type="checkbox"/> February | <input type="checkbox"/> June | <input type="checkbox"/> October |
| <input type="checkbox"/> March | <input type="checkbox"/> July | <input type="checkbox"/> November |
| <input type="checkbox"/> April | <input type="checkbox"/> August | <input type="checkbox"/> December |
| AMP Confirmation | | |
| I would like my AMP Orthotic Fitter examination confirmation sent to me by: | | <input type="checkbox"/> Email <input type="checkbox"/> USPS |
| *I have provided my email and/or address on the front of this application. | | |
| Payment Type | Payment Amount | FYI |
| Application | \$150 | *Please go to www.bocusa.org for the most current BOC updates. |
| Multiple Choice Exam | \$200 | |
| TOTAL DUE | \$350 | |
| <i>Exam results will not be distributed without payment of exam fees. All fees are non-refundable.</i> | | |
| Credit Card Payment <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover | Expiration Date | Check Payment <input type="checkbox"/> Check (enclosed) |
| Credit Card Number* | | Check Number** |
| Billing Address | | |
| City | State/Province | Zip/Postal Code |
| Name as it appears on card | | |
| Cardholder Signature | | |

*The issuer of the card identified on this form is authorized to pay the amount shown as TOTAL upon proper presentation. I agree to pay such TOTAL (together with any other charges due thereon) subject to and in accordance with the Agreement governing the use of such card.

**Make Check or Money Order (in U.S. Dollars) payable to BOC. If your check is returned for any reason, you must submit a bank draft, money order or credit card payment with an additional fee of \$35.00 to cover the returned check processing fee.

Submit completed application and entry-level certificate to:

Board of Certification/Accreditation, International
Attention: Certification Department
10451 Mill Run Circle, Suite 200
Owings Mills, Maryland 21117

You may fax or email this application in advance of mailing BOC your entry-level certificate.

Email: cert@bocusa.org

Direct fax line for Wendy Solomon, Certification Coordinator: (410) 753-8801