



## Application for BOC Certification Examination – Retake

Application Type			
Check program(s) for which you are retaking. You may retake exams for more than one program using this application.			
<input type="checkbox"/> Orthotist (BOCO®) <input type="checkbox"/> Pedorthist (BOCPD™) <input type="checkbox"/> Mastectomy Fitter (CMF®) <input type="checkbox"/> Prosthetist (BOCP®) <input type="checkbox"/> Orthotic Fitter (COF®)			
What year did you first submit your application? _____			
Preferred Information & Address			
First Name	Last Name	Middle Initial	
Street Address			Apartment Number
City	State/Province	Zip/Postal Code	Mobile Number (include area code)
Email Address	Telephone Number (include area code)		Is 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			
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
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
<b>If you answered "Yes" to any of the above, please enclose an explanation on a separate sheet.</b>			
Attestation			
I attest that the information reported on this application is true and accurate to the best of my knowledge.			
_____ Signature			_____ Date (mm/dd/yyyy)



**Exam Month (Please Choose One)**

- January
- February
- March
- April
- May
- June
- July
- August
- September
- October
- November
- December

**AMP Confirmation**

I would like my AMP Mastectomy Fitter examination confirmation sent to me by:  Email  USPS

\*I have provided my email and/or address on the front of this application.

**Payment Information**

Indicate the total payment based on the exam(s) for which you are retaking. <b>Payment Enclosed:</b> \$ _____	Fee (in USD)	Orthotist (BOCO)	Prosthetist (BOCP)	Pedorthist (BOCPD)	Certified Orthotic Fitter (COF)	Certified Mastectomy Fitter (CMF)
	Multiple Choice Exam		\$300	\$300	\$250	\$200
Clinical Simulation Exam		\$300	\$300	n/a	n/a	n/a

Credit Card Payment* <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover	Check Payment** <input type="checkbox"/> Check (enclosed)      Check Number: _____
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Credit Card Number	Security Code	Expiration Date
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Billing Address

City	State/Province	Zip/Postal Code
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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 check is returned for any reason, we must receive 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 to:**

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

**You may also fax or email this application.**

Email: [cert@bocusa.org](mailto:cert@bocusa.org)  
 Direct fax line for Wendy Solomon, Certification Coordinator: (410) 753-8801

**FOR INTERNAL USE ONLY**

Date Received: \_\_\_\_\_      Amount Received: \_\_\_\_\_      Date Processed: \_\_\_\_\_      Staff Initials: \_\_\_\_\_