Orthotist or Prosthetist Application for Renewal of Residency Registration

Board of Orthotists & Prosthetists
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: www.floridasorthotistsprosthetists.gov
Email: info@floridasorthotistsprosthetists.gov
Phone: (850) 245-4292
FAX: (850) 413-6982

Florida HEALTH
Medical Quality Assurance

Are you an active duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered “Yes” to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health’s commitment to serving members and veterans of the United States Armed Forces and their families online at

http://www.flhealthsource.gov/valor

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Medical Quality Assurance

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Do Not Write in this Space For Revenue Receipting

Select One Renewal Type:

☐ Orthotist (3109) **$130.00** ☐ Prosthetists (3110) **$130.00**

☐ Dual Orthotist & Prosthetist (3111) **$130.00**

Total fee includes the following:

Registration Renewal Fee	$125.00
Unlicensed Activity Fee	$5.00

Residency Registration #: _____

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. A registration renewal is permitted only once in each specific residency discipline by statute and is limited to one year, as stated in section (s.) 468.803(3), Florida Statutes (F.S.).

Rule 64B14-4.115, Florida Administrative Code (F.A.C.) requires the renewal registration application be received by the department prior to the expiration of the original registration. Renewals may not be submitted any earlier than 150 days prior to the expiration of your current registration. **Failure to receive an approved renewal of your Residency prior to the expiration date results in your registration expiring. If your registration expires, you must cease practicing as a resident in the state of Florida.**

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone (Input without dashes)

Practice Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website)

_____ _____ _____
Street (Place of Employment) Suite. No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone (Input without dashes)

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

☐ Yes ☐ No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Name: _____

2. SUPERVISOR INFORMATION

This section must be completed by Resident Applicant's Supervisor.

_____

Supervisor Name | Florida License Number | ABC Certification Number*

_____

Name of Practice | Practice Telephone

_____

Practice Street Address | City | State | ZIP

Date Residency Starts: _____ (MM/DD/YYYY)

Date Residency Ends: _____ (MM/DD/YYYY)

**American Board for Certification in Orthotics, Prosthetics, and Pedorthics, Inc. (ABC)*

I agree to supervise the referenced resident in accordance with the requirements set forth in Rule 64B14-4.100, F.A.C. The above information is true and correct.

_____ _____

Supervisor Signature | Date (MM/DD/YYYY)

3. RESIDENT STATEMENT

I agree to abide by the laws and rules of the state of Florida and to follow the direction of my supervisor in accordance with the requirements set forth by Rule 64B14-4.100, F.A.C. I further agree that if this supervision is terminated for any reason, I shall inform the board in writing within thirty business days.

I, _____, certify the above information is true and correct.
Print Name

_____ _____

Residency Applicant Signature | Date (MM/DD/YYYY)

All applicants must submit **legible copies of current employment identification badges**.

Name: _____

This information is exempt from public records disclosure.

4. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? ☐ Yes ☐ No

Substance-Related Disorders Impacting Ability to Practice

C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse? ☐ Yes ☐ No

E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? ☐ Yes ☐ No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

☐ **A letter from a Licensed Health Care Practitioner,** who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

☐ **A written self-explanation,** identifying the medical condition(s) or occurrence(s); and current status.

Documents in this section must be mailed to:

Board *of* Orthotists & Prosthetists
4052 Bald Cypress Way, Bin C-08
Tallahassee, FL 32399-3258

Name: _____

5. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), F.S.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 2.

   a. If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

   b. If "Yes" to 1, for the felonies of the third degree, has it been more than ten years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), F.S.)? ☐ Yes ☐ No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

   d. If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed (if "Yes," provide supporting documentation)? ☐ Yes ☐ No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 3.

   a. If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? ☐ Yes ☐ No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, F.S.? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 4.

   a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? ☐ Yes ☐ No

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 5.

a. Have you been in good standing with a state Medicaid program for the most recent five years? ☐ Yes ☐ No

b. Did termination occur at least 20 years before the date of this application? ☐ Yes ☐ No

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? ☐ Yes ☐ No

a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? ☐ Yes ☐ No

b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-explanation** for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation.

☐ **Supporting documentation** including court dispositions or agency orders where applicable.

Documentation for this section must be sent to the Background Screening Unit at MQA.BackgroundScreen@flhealth.gov or mailed to:

Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL 32399

6. APPLICANT SIGNATURE

The information contained in this application is true and accurate. I hereby authorize all references, education institutions, employers, business and professional organizations and associates, to provide the Department of Health any information requested in connection with the processing of this application. I understand that it is my duty and responsibility as a resident for licensure to supplement my application after it has been submitted if and when any material change in circumstance or conditions occur which might affect the department's decision concerning my eligibility for licensure.

I have carefully read the questions in the foregoing application and have answered them completely and I confirm that my answers and all statements made by me herein are true and correct. I understand that if I provide false information that such action shall constitute cause for denial, suspension, or revocation of licensure to practice for which I am applying in the state of Florida.

Applicant Signature _____ Date _____
You may print this application and sign it or sign digitally. MM/DD/YYYY

Note: It is a third-degree felony to knowingly give false information in the course of applying for or obtaining a license from the Department, with the intent to mislead a public servant in the performance of official duties in accordance with s. 456.067, F.S.

An incomplete application shall expire one year after initial filing with the department.

Complete verifications must be mailed directly to:

Board *of* Orthotists & Prosthetists
4052 Bald Cypress Way, Bin C-08
Tallahassee, FL 32399-3258

Board *of* Orthotists & Prosthetists
Verification of Clinical Experience

Part I: To be completed by Resident

Name: _____
Last First Middle

Resident Registration Number: _____

Part II: To be completed by Resident's Supervising Practitioner

Employer Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Country: _____ Telephone Number: _____

Dates of resident's work experience: From: _____ To: _____
MM/DD/YYYY MM/DD/YYYY

Complete description of job responsibilities:

_____

_____

_____

_____

_____

_____

Part III: To be completed by supervisor

_____
Supervisor Name (Print) Florida License Number ABC Certification Number

The above information is accurate to the best of my knowledge.

_____
Supervisor Signature Date (MM/DD/YYYY)