

CERTIFICATION INFORMATION

5. Have you successfully passed the ABC examination in the applied discipline?

- YES NO

DATE OF EXAMINATION: _____

LICENSE HISTORY

INSTRUCTIONS: If you are now or have ever been licensed to practice as an Orthotist or Prosthetist in another state, original verifications of license history certification is required for each permanent, temporary, training, provisional, or limited license obtained in any state in the US or Canadian territory, Canadian province, or US Federal jurisdiction. The issuing authority should mail the verification to the Medical Board. If licensed by examination, give the state. If licensed by reciprocity, provide the state. Provide the current status of the license: active, inactive, revoked, suspended, probation, limited, etc. You may make copies of this page if more space is needed. Please complete FORM C and forward to the issuing State to request verification be sent "directly" to the Medical Board.

STATE/COUNTRY

DATES OF LICENSURE (MM/DD/YY TO MM/DD/YY)

LICENSED BY

CURRENT STATUS OF LICENSE

STATE/COUNTRY

DATES OF LICENSURE (MM/DD/YY TO MM/DD/YY)

LICENSED BY

CURRENT STATUS OF LICENSE

STATE/COUNTRY

DATES OF LICENSURE (MM/DD/YY TO MM/DD/YY)

LICENSED BY

CURRENT STATUS OF LICENSE

TRAINING

INSTRUCTIONS: Provide the name of your training program or college. Indicate all beginning and ending months and years of each of attendance. All gaps in the chronological progression of your training must be explained on a separate piece of paper, i.e., leave of absences, sabbaticals, taking a year off to work in order to pay for the next year of training, etc

EDUCATION

NAME OF COLLEGE ATTENDED	DATES OF ATTENDANCE – MONTH AND YEAR (MM/YY TO MM/YY)
	1 ST YEAR
	2 ND YEAR
	3 RD YEAR
	4 TH YEAR

NAME: _____

SS#: _____

APPLICANT QUESTIONNAIRE

INSTRUCTIONS: If you answer, "YES" to questions 1-12, you are required to furnish complete details, including date, place, reason and disposition of the matter. Failure to furnish complete documentation may result in a delay in the processing of your application. I understand that my questionnaire may be selected for verification of the information provided. I recognize that providing false information or incomplete information may result in disciplinary actions against my license pursuant to O.C.G.A. §§ 43-1-19 and may result in criminal penalties, up to and including reporting to the Health Integrity and Protection Databank (HIPDB).		
	YES	NO
1. Have you ever been treated or hospitalized for mental illness, drug or alcohol abuse during the last seven years? (Provide the Board with all treatment history documentation to include diagnosis, treatment regimen, medical regimen, hospitalization, and on-going treatment/medication.)	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been arrested and/or convicted of a violation of any Federal (including military), State or Local statute?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been denied the privilege of taking an examination given by any licensing Board or agency?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has any licensing Board or agency ever denied you a certificate or a license?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has any licensing Board or agency ever taken disciplinary action against you?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has any licensing Board or agency ever refused you renewal of a certificate or a license?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been denied membership in or in any way sanctioned by any Orthotics and/or Prosthetics association, society, or specialty society?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever voluntarily surrendered a license?	<input type="checkbox"/>	<input type="checkbox"/>
9. To your knowledge, are you the subject of an investigation by any licensing Board or agency as of the date of this application?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have any applications for licensure pending before any other licensing Board or agency?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever been convicted of Medicaid or Medicare fraud, or had any restrictions as a Medicaid or Medicare provider?	<input type="checkbox"/>	<input type="checkbox"/>
12. Are you in default on a state or federally funded and/or guaranteed school loan?	<input type="checkbox"/>	<input type="checkbox"/>

Required Coursework

Instructions: If you selected associates degree as meeting the transcript requirements, please complete the information below. List the titles and numbers of courses from your transcript(s) which satisfy the content area requirements. **PLEASE SUBMIT A TRANSCRIPT.**

Human Anatomy

Institution	Course # and Title	Date Completed

Physiology

Institution	Course # and Title	Date Completed

Physics

Institution	Course # and Title	Date Completed

Chemistry

Institution	Course # and Title	Date Completed

Biology

Institution	Course # and Title	Date Completed