

\*\*\*FOR OFFICE USE ONLY\*\*\*

**Prosthetist/Orthotist Checklist**

- Endorsement       Examination
- App. & Fee
- Date: \_\_\_\_\_ Check \_\_\_\_\_
- Photo
- Transcript of baccalaureate
- Transcript of Prosthetic/Orthotic Program
- ABCOP or BOC Certification
- Clinical Residency Verification
- Lic. Verification from other States



\*\*\*FOR OFFICE USE ONLY\*\*\*

Application Approved:
License Number:
Issue Date:
Signature of Board Administrator
ID#:
Receipt #:

**Rhode Island  
Department of Health  
Office of Health Professionals Regulation**

Room 104  
3 Capitol Hill  
Providence, RI 02908-5097

***Instructions and Application For  
License As A(n)***

- Prosthetist       Orthotist

By

- Endorsement**  
 **Examination**

License # \_\_\_\_\_  
Name \_\_\_\_\_

*Applicant - Print Name (First/MI/Last)*

# GENERAL INFORMATION

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## Enclosures

The following materials and information should be enclosed within this application packet:

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## Prosthetist Requirements

- Fee of **\$120.00** (NON-REFUNDABLE).
- Recent passport type photograph (approximately 2" X 2", head and shoulder view).
- Official transcripts of baccalaureate degree
- Official transcripts of your prosthetics program
- Certificate/Documentation of completion of a clinical residency in prosthetics that meets or exceeds the standards of the National Commission on Orthotic and Prosthetic Education.
- Current certification by the *American Board for Certification in Orthotics and Prosthetics* (ABCOP) or the Board of Certification/Accreditation (BOC) - (original or notarized copy)

## Orthotist Requirements

- Fee of **\$120.00** (NON-REFUNDABLE).
- Recent passport type photograph (approximately 2" X 2", head and shoulder view).
- Official transcripts of baccalaureate degree
- Official transcripts of your orthotics program
- Certificate/Documentation of completion of a clinical residency in orthotics that meets or exceeds the standards of the National Commission on Orthotic and Prosthetic Education.
- Current certification by the *American Board for Certification in Orthotics and Prosthetics* (ABCOP) or the Board of Certification/Accreditation (BOC) - (original or notarized copy)

## Endorsement Applicants

In addition to requirements listed above:

- License Verifications from the state(s) in which applicant holds or has held a license (use "Interstate Verification form - Other States of Licensure" form, on page 10, for this purpose).

# APPLICATION PROCESS OVERVIEW

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The licensure process in the State of Rhode Island is conducted by the Rhode Island Department of Health (HEALTH), Office of Health Professionals Regulation (Office).

## **Application Process**

In addition to the application, you must submit additional information directly to the Office. All items listed on the “checklist” (page 9) must be submitted for an application to be considered complete. All applications are considered valid for 1 year from the day they are received at HEALTH. If you do not complete the application process and obtain a license within 1 year a new application must be submitted.

Please allow a minimum of 4-6 weeks for the entire licensure process to be completed. If you have malpractice criminal or disciplinary history, in Rhode Island or another state, it can take an additional 2 or 3 months for all pertinent documentation to be received, and a decision to be made regarding issuance of your license.

Licenses will be issued within 7-10 working days following approval of the license. You are responsible for notifying the Department, in writing, if your address changes in the interim. Visit the following website to obtain a change of address form.

<http://www.health.ri.gov/forms/changeofaddress/professions.pdf>

***To obtain your license number prior to receiving your license card, please refer to the HEALTH Licensee Lookup web site:***

<https://healthri.mylicense.com/Verification/>

HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others. Once completed, the application will be reviewed, and you will be contacted in writing.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the application. If you have any questions about this application process, or would like to check on the status of your application, please contact the board staff at (401) 222-2828.

## **General Law**

Title 5, Chapter 59.1, entitled: RI Orthotics & Prosthetics Practices can be downloaded at the following web site:

<http://www.rilin.state.ri.us/statutes/title5/5-59.1/>

# INSTRUCTIONS FOR COMPLETING THE LICENSE APPLICATION

Read the following instructions and those throughout the application packet carefully before completing the application. **Only complete applications with the appropriate fee will be accepted.** Failure to submit all required information and appropriate documentation may result in processing delays.

## General Instructions

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. HEALTH staff will not make assumptions about illegible information.
3. Provide a response to each section or question; otherwise mark "N/A" for Not Applicable.
4. We suggest that you make a copy of your completed application before submitting it to HEALTH.
5. It is your responsibility to check on the status of your application.

## Completing your Application for Prosthetist and/or Orthotist

1. Complete the application (pages 5-8). You must respond to all components of the application as instructed. If you attach separate pages in continuation of the application, such pages **MUST** clearly indicate the section for which such information is being reported.
2. Make check or money order (in U.S. funds only) for the application fee of **\$120.00** payable to the "**Rhode Island General Treasurer**" and staple it to the upper left-hand corner of the first (Top) page of the application. This application fee is NON-REFUNDABLE.
3. Affix a recent **2 X 2 photo** of yourself in the space provided (page 8).
4. Completed official transcripts of your baccalaureate degree **sent directly** from the educational institution to the Rhode Island Department of Health, Room 104.
5. Current certificate/documentation from either the "American Board for Certification in Orthotics and Prosthetics" (ABCOP) (**Telephone 1-703-836-7114**) (**Website: <http://www.abcop.org/>**) or the Board of Certification/Accreditation (BOC) (**Telephone 1-877-776-2200**) (**Website: [www.bocusa.org](http://www.bocusa.org)**) **sent directly** from the ABCOP/BOC to the Rhode Island Department of Health, Room 104.
- 6a. **For Prosthetists** - Official transcripts of your prosthetics education program **sent directly** from the educational institution to the Rhode Island Department of Health, Room 104 and;  
Certificate/Documentation of completion of a clinical residency in prosthetics that meets or exceeds the standards of the National Commission on Orthotic and Prosthetic Education.
- 6b. **For Orthotists** - Official transcripts of your orthotics education program **sent directly** from the educational institution to the Rhode Island Department of Health, Room 104 and;  
Certificate/Documentation of completion of a clinical residency in orthotics that meets or exceeds the standards of the National Commission on Orthotic and Prosthetic Education.
7. **Endorsement Candidates Only:** Please send the license verification form on page 10 to all states in which **applicant** holds or has held a license. Be sure to sign and complete the identifying information on the form. HEALTH must receive these verifications **directly** from the licensing authority in each state.

8. Mail the application and documentation to:

**Rhode Island Department of Health  
Office of Health Professionals Regulation , Room 104  
3 Capitol Hill  
Providence, RI 02908-5097**



# State of Rhode Island Department of Health

## Application for License as a Prosthetist or Orthotist

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

### 1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/ Permit/ Certificate. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

### 2. Social Security Number

 -  - 

U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Division of Taxation to verify that no taxes are owed to the State."

### 3. Gender

 Male  Female

### 4. Date of Birth

 /  /  **1** **9** 

Month

Day

Year

### 5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

Country, If NOT U.S.

 - 

Home Phone

State

 - 

Zip Code

Postal Code, If NOT U.S.

 - 

Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

### 6. Business Address

(ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

***This address will appear on the Department of Health web site.***

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

Country, If NOT U.S.

 - 

Business Phone

Extension

State

 - 

Zip Code

Postal Code, If NOT U.S.

 - 

Business Fax



**11. Criminal Convictions**

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending?

Yes  No

Abbreviation of State and Conviction<sup>1</sup> (e.g. CA - Illegal Possession of a Controlled Substance):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Month		Year	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**12. Disciplinary Questions**

Check either Yes or No for each question.



1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are formal charges pending?

Yes  No

2. Have you ever been denied a license, certificate, registration or permit in any state?

Yes  No

**Note:** If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, on a separate sheet of paper.

**13. Affidavit of Applicant**

Complete this section and sign in the presence of a notary public.

Make sure that you and the notary public have completed all components accurately and completely.

I, \_\_\_\_\_, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a Prosthetist/Orthotist in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health, Office of Health Professionals Regulation of any change in the answers to these questions after this application and this affidavit is signed.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date of Signature (MM/DD/YY)

The foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, by \_\_\_\_\_, who is personally known to me or has produced \_\_\_\_\_ as documentation and did / did not take an oath.

\_\_\_\_\_  
Name of Notary (Print, Type or Stamp)

\_\_\_\_\_  
Signature of Notary

\_\_\_\_\_  
Notary No/Commission No.

\_\_\_\_\_  
Commission Expiration Date (MM/DD/YY)

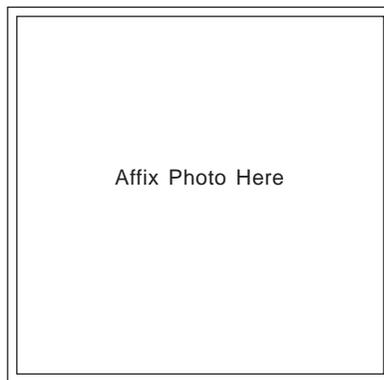


**14. Recent Photograph**

Securely tape or glue in this square a current 2" x 2" photograph of yourself (alone).

Photographs must be recent, passport type photo, clear, front view, full face without a hat or dark glasses.

Full length photos will not be accepted.



**Write your name on the back of the photograph, and provide the date that the photograph was taken.**

\_\_\_\_\_  
Date of Photograph

# APPLICATION CHECKLIST

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Please review the following checklist to ensure that all the components of the application process have been satisfied. Some items may not apply.

## Board Application

- I have read and understand the “Instructions for Completing the Application”.
- I have completed the Rhode Island HEALTH application as instructed (pages 5-8).
- I have attached the cover page of the application.
- I have completed Section 13, “**Affidavit of Applicant**”, and had the form notarized by a notary public.
- I have attached a photograph to Section 14, “**Recent Photograph**” as instructed. I have verified that it meets the photograph requirements as stated in the application.
- I have a **check or money order** (preferred), made payable (in U.S. funds only) to the: “**Rhode Island General Treasurer**” in the amount of **\$120.00** and attached it to the upper left-hand corner of the first (Top) page of the application.
- I have arranged my License Application materials in the following order.
  1. Fee (attached as instructed).
  2. License Application (including cover page) and pages 5-8.
  3. Supporting documentation as required. [**Note:** Pages containing additional information in continuation of the License application] **MUST** indicate the section for which the information is being reported.]
- I have mailed the above application materials directly to the Rhode Island Department of Health, Room 104.

## Required Forms (Endorsement Applicants Only)

- I have completed and mailed the following forms as instructed.
  1. Interstate Verification Form(s) - Other State License(s).

## Other Documents (All Applicants)

- I have requested a copy of my transcripts of my baccalaureate degree
- I have requested a copy of transcripts of my prosthetic education program.
- I have requested a copy of transcripts of my orthotic education program.
- I have requested a current certificate/documentation of my certification from the American Board for Certification in Orthotics and Prosthetics (ABCOP) or the Board of Certification/Accreditation (BOC).
- I have requested a certificate/documentation of completion of a clinical residency in prosthetics that meets or exceeds the standards of the National Commission on Orthotic and Prosthetic Education.
- I have requested a certificate/documentation of completion of a clinical residency in orthotics that meets or exceeds the standards of the National Commission on Orthotic and Prosthetic Education.



*Substitute forms are not acceptable, copy this form as needed.*

**Rhode Island Department of Health**  
 Office of Health Professionals Regulation, Room 104  
 3 Capitol Hill  
 Providence, RI 02908-5097  
 (401) 222-2828

**INTERSTATE VERIFICATION FORM - OTHER STATE LICENSURE**

I am applying for a license to practice as a Prosthetist/Orthotist in the State of Rhode Island. The Rhode Island Department of Health requires that the following form be completed by the jurisdiction(s) in which I hold or have held a license. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Department of Health at the above address.

Print/Type Full Name	Signature	Date
Previous Names Used	Social Security Number	Date of Birth
License Number	Date Issued	

**THIS SECTION TO BE COMPLETED BY THE PROSTHETICS/ORTHOTICS BOARD**

Prosthetics/Orthotics Program Completed:	Location:	Graduation Date:
Licensed by Examination? <input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant has completed and passed the National Certification Exam: <input type="checkbox"/> Yes <input type="checkbox"/> No	
License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed	Original Date Issued:	Expiration Date:

**Questions:**

1. Has this licensee ever been investigated by your Board?  Yes    No
2. Has this licensee incurred any disciplinary proceedings in your state, or is any action pending?  Yes    No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation?  Yes    No
4. Do you know of any information that may discredit this person?  Yes    No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

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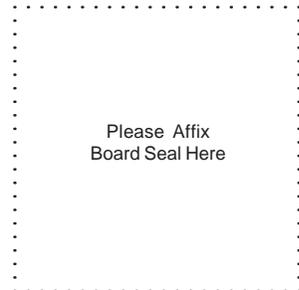
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**Certification:**

Signature	Date
Type or Print Name	
Title	
Full Name of Licensing Board	



*Please return directly to the Department at the above address. Thank you for your prompt cooperation.*