

**Regular Mailing Address**  
**STATE BOARD OF MEDICINE**  
**P.O. BOX 2649**  
**HARRISBURG, PA 17105-2649**  
**Email: [st-medicine@pa.gov](mailto:st-medicine@pa.gov)**

**Courier Delivery Address**  
**STATE BOARD OF MEDICINE**  
**2601 NORTH THIRD STREET**  
**HARRISBURG, PA 17110**  
**Medicine – 717-783-1400/717-787-2381**

## APPLICATION FOR A ORTHOTIST GRADUATE PERMIT

1.	Submit the <b>\$50</b> fee via check or money order, made payable to the "Commonwealth of Pennsylvania." <b><u>FEES ARE NOT REFUNDABLE.</u></b> Note: A processing fee of \$20 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment. Your cancelled check is your receipt.
2.	If documents will be submitted to the Board under a name different from your present name, submit a copy of the legal document evidencing the name change (i.e., marriage license, divorce decree, naturalization, etc.).
3.	<b>You may not practice in the Commonwealth of Pennsylvania until the Pennsylvania State Board of Medicine has issued you an Orthotist Graduate Permit and you have obtained professional liability insurance.</b>
<p><b>PLEASE NOTE:</b> If a pending application is older than one year from the date submitted and the applicant wishes to continue the application process, the Board shall require the applicant to submit a new application including the required fee. In order to complete the application process, many of the supporting documents associated with the application cannot be more than six months from the date of issuance.</p>	
<p><b><u>An Orthotist Graduate Permit is valid during the clinical residency and for up to 90 days after successful completion of the clinical residency or until a provisional license is issued, whichever occurs first.</u></b>  <b><u>An Orthotist Graduate Permit is not renewable.</u></b></p>	
4.	The Bureau of Professional and Occupational Affairs (BPOA), in conjunction with the Department of Human Services (DHS), is providing notice to all health-related licensees and funeral directors that are considered "mandatory reporters" under section 6311 of the Child Protective Services Law (CPSL) (23 P.S. § 6311), as amended, that EFFECTIVE JANUARY 1, 2015, all persons applying for issuance of an initial license shall be required to complete 3 hours of DHS-approved training in child abuse recognition and reporting requirements as a condition of licensure. Please review the Board website for further information on approved CE providers. Once you have completed a course, the approved provider will electronically submit your name, date of attendance, etc., to the Board. <a href="#">Child Abuse Continuing Education Providers Information can be found here.</a>
5.	Complete Section 1 of the Verification of Orthotist or Prosthetist/Orthotist Education Form and forward to the program where you obtained a bachelor's degree, post-baccalaureate certificate or higher degree from a Commission on Accreditation of Allied Health Education Programs (CAAHEP) accredited education program with a major in orthotics or prosthetics and orthotics and request that they complete Section 2. <b>The program must return the completed verification, along with an official copy of your transcript, <u>directly to the Board.</u></b>
6.	Contact the National Commission on Orthotic and Prosthetic Education (NCOPE) and request that they provide proof that you have registered for an Orthotist or Prosthetist/Orthotist residency program. <b>The program must send the verification <u>directly to the Board.</u></b>
7.	Provide proof of professional liability insurance coverage through self-insurance, personally purchased insurance or insurance provided by your employer for the minimum amount of \$1,000,000.00 per occurrence or claims made. <b>This proof of insurance/certificate must include your name and indicate that you are covered under this policy while performing Orthotist services in the Commonwealth of Pennsylvania.</b>
8.	Contact the state board office(s) where you hold or have ever held a license, certificate, permit, registration or other authorization to practice a profession or occupation and request letters of good standing. The letter must include the following: license issue and expiration date, license status (current or expired) and disciplinary standing. The letter(s) of good standing must be sent directly to the Board.
9.	Provide an official notification of information (Self Query) from the National Practitioner Data Bank. Please refer to the NPDB website for additional information. <b>When you receive the "Response to your Self Query," forward the entire report directly to the Board Office.</b> <u>You should make a copy for your records.</u>
10.	Attach a current Curriculum Vitae listing <b>all</b> periods of employment or unemployment (i.e., child rearing, etc.) from graduation from your Orthotist or Prosthetist/Orthotist program to present. The list must be in chronological order, include the month and year, and indicate the state/territory in which the employment occurred.



## LEGAL QUESTIONS

**You must answer the following questions.** If you answer "YES" to #2 through #12, provide complete details on a separate sheet as well as certified copies of relevant documents.

		Yes	No
1	Do you hold or have you ever held a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction? <b>If you answered yes, provide the profession and state or jurisdiction.</b> <b>LIST:</b> _____		
2	Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
3	Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?		
4	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
5	Have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		
6	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?		
7	Have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?		
8	Have you had your DEA registration denied, revoked or restricted?		
9	Have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?		
10	Have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		
11	Have you engaged in, the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?		
12	Have you been the subject of a civil malpractice lawsuit? <b>If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. Submit a statement which includes complete details of the complaints that have been filed against you.</b> <b>**If you previously reported the complaint to the Board provide the docket number _____</b>		

## SIGNED STATEMENT

NOTICE: Disclosing your Social Security Number on this application is mandatory in order for the State Boards to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. § 4304.1(a). At the request of the Department of Human Services, the licensing boards must provide to the Department of Human Services information prescribed by the Department of Human Services about the licensee, including the social security number. In addition, Social Security Numbers are required in order for the Board to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa. C.S. Section 4911. I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Applicant

**PENNSYLVANIA STATE BOARD OF MEDICINE**

**VERIFICATION OF ORTHOTIST OR  
PROSTHETIST/ORTHOTIST EDUCATION**

**SECTION 1 – TO BE COMPLETED BY APPLICANT**

<b>NAME:</b>	Last	First	Middle
<b>NAME OF ORTHOTIST or PROSTHETIST/ORTHOTIST EDUCATION PROGRAM:</b>			
<b>ADDRESS:</b>	City	State	Zip

Submit the verification of education form to your Orthotist or Prosthetist/Orthotist program and request the program return the completed form, along with your official transcript, directly to the board.

**SECTION 2 – TO BE COMPLETED BY DEAN OR REGISTRAR OF ORTHOTIST  
OR PROSTHETIST/ORTHOTIST PROGRAM**

<b>NAME OF ORTHOTIST OR PROSTHETIST/ORTHOTIST EDUCATION PROGRAM:</b>			
<b>NAME OF STUDENT:</b>	Last	First	Middle
<b>DATE STUDENT BEGAN TO ATTEND THIS PROGRAM:</b>	Month	Day	Year
<b>DATE OF GRADUATION:</b>	Month	Day	Year

**I CERTIFY THAT ALL OF THE INFORMATION LISTED ABOVE IS CORRECT**

<b>NAME OF DEAN/REGISTRAR:</b>	Last	First	Middle
--------------------------------	------	-------	--------

<b>SIGNATURE OF DEAN/REGISTRAR:</b>			
-------------------------------------	--	--	--

<b>DATE:</b>	Month	Day	Year
--------------	-------	-----	------

Upon completion, program must return this completed form directly to the Pennsylvania State Board of Medicine in an official envelope.

(Seal of Program)

**DO NOT RETURN THIS FORM  
TO THE APPLICANT**

**Regular Mailing Address**  
STATE BOARD OF MEDICINE  
P.O. BOX 2649  
HARRISBURG, PA 17105-2649  
717-783-1400/717-787-2381

**Courier Delivery Address**  
STATE BOARD OF MEDICINE  
2601 NORTH THIRD STREET  
HARRISBURG, PA 17110