

Application for BOC Certification



Application Type

Check program(s) for which you are applying. You may apply for more than one certification using this application.

- | | |
|--|---|
| <input type="checkbox"/> Orthotist (BOCO®) | <input type="checkbox"/> Orthotic Fitter (COF®) |
| <input type="checkbox"/> Prosthetist (BOCP®) | <input type="checkbox"/> Mastectomy Fitter (CMF®) |
| <input type="checkbox"/> Pedorthist (BOCPD™) | |

When would you like to take your examination(s)?

- February May August November Year: _____

Pending review of your documentation, you will be registered for the multiple choice and clinical simulation exams in the exam window requested. To be eligible for your requested exam time, all documentation must be received on the 15th of the month prior to your selection.

Personal Information

First Name		Last Name		Middle Initial	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Home Street Address				Apartment Number	
City	State/Province	Zip/Postal Code	Country		
E-mail Address		Telephone Number (include area code)		Fax Number (include area code)	
Date of Birth (mm/dd/yyyy)		Social Security Number / Canadian Health Number		Preferred Mailing Address <input type="checkbox"/> Home <input type="checkbox"/> Work	

Please exclude my contact information from distribution to third parties.

Professional Information

Education Level (check highest level completed, and fill in the year of completion)

- | | | | |
|---|-------------|---|-------------|
| <input type="checkbox"/> High School | Year: _____ | <input type="checkbox"/> Baccalaureate | Year: _____ |
| <input type="checkbox"/> Associate Degree | Year: _____ | <input type="checkbox"/> Post Baccalaureate | Year: _____ |

Current Professional Credentials (examples: BOCO, BOCP, COF, etc.)

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 ever been named as a defendant in a professional liability suit during the past five years? Yes No
- Have there been any settlements or judgments involving your professional practice during the past five years? Yes No
- Has your professional certification or license ever been restricted, limited, reduced, denied, suspended, revoked or cancelled? Yes No
- Have you ever been convicted of a felony? Yes No
- Has Medicaid or any other medical reimbursement plan ever brought formal charges against you for alleged inappropriate fees or Quality of Care issues? Yes No
- Has your professional liability coverage ever been restricted, limited, denied, or denied renewal? Yes No

If you answered "Yes" to any of the above, please enclose an explanation on a separate sheet.

Attestation

I attest that the information reported on this application, and in all accompanying documentation is true and accurate to the best of my knowledge.

Signature

Date (mm/dd/yyyy)

Your initials below verify that you understand that the following requirements must accompany this application.

_____ I have included my résumé, including details regarding how I meet this certification's work experience requirements.

_____ The enclosed Résumé Verification Form has been signed by my supervisor and notarized.

_____ My transcript(s) or course certificate(s) is included to show that I meet this certification's education prerequisites.

Payment Information

Fee (in USD)	Orthotist (BOCO)	Prosthetist (BOCP)	Pedorthist (BOCPD)	Orthotic Fitter (COF)	Mastectomy Fitter (CMF)
Application	\$300	\$300	\$150	\$150	\$50
Multiple Choice Exam	\$300	\$300	\$250	\$200	\$150
Clinical Simulation Exam	\$300	\$300	n/a	n/a	n/a
Video Practical Exam	\$300	\$300	n/a	n/a	n/a
TOTAL DUE*	\$1200	\$1200	\$400	\$350	\$200

Indicate the total payment based on the program(s) for which you are applying.

Payment Enclosed:

\$ _____

** Exam fees payable prior to the date you submit or sit for exam(s). Note that exam results will not be distributed without payment of all exam fees. All fees are non-refundable.*

Credit Card Payment*

Visa MasterCard Discover

Expiration Date

Check Payment**

Check (enclosed)

Credit Card Number

Check Number

Billing Address

City

State/Province

Zip/Postal Code

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 and materials to:

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

You may fax or e-mail this application in advance of mailing BOC your application materials.

E-mail: cert@bocinternational.org

Direct fax line for Wendy Solomon, Certification Assistant: (410) 753-8801

FOR INTERNAL USE ONLY

Date Received: _____ Amount Received: _____ Date Processed: _____ Staff Initials: _____