



BOC Pedorthist Application

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
Email Address	Telephone Number (include area code)		Mobile 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
<input type="checkbox"/> 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
Patient Care and Experience Requirement			
I have a minimum of 1000 hours (approximately 25 weeks of full-time work) of documented patient care. Please keep patient logs or a notarized letter of attestation from your supervisor readily available.			<input type="checkbox"/> Yes <input type="checkbox"/> No
I have included a copy of the certificate of attendance from a BOC-approved Pedorthic entry-level course.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Questionnaire			
Have you been named as a defendant in a professional liability suit during the past five years?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Any professional practice judgments or settlements against you in the past five years?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your professional certification/license ever been affected negatively by any agency?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been convicted of one or more felonies?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Has Medicaid or any other medical plan ever brought charges against you for any reason?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your professional liability coverage ever been restricted, limited, denied, or denied renewal?			<input type="checkbox"/> Yes <input type="checkbox"/> 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. Yes No

Exam Month (Please Choose One)

- | | | |
|-----------------------------------|---------------------------------|------------------------------------|
| <input type="checkbox"/> January | <input type="checkbox"/> May | <input type="checkbox"/> September |
| <input type="checkbox"/> February | <input type="checkbox"/> June | <input type="checkbox"/> October |
| <input type="checkbox"/> March | <input type="checkbox"/> July | <input type="checkbox"/> November |
| <input type="checkbox"/> April | <input type="checkbox"/> August | <input type="checkbox"/> December |

AMP Confirmation

I would like my AMP Pedorthist examination confirmation sent to me by: Email USPS

*I have provided my email and/or address on the front of this application.

Payment Type	Payment Amount	FYI
Application	\$150	*Please go to www.bocusa.org for the most current BOC updates.
Multiple Choice Exam	\$250	
TOTAL DUE	\$400	

Exam results will not be distributed without payment of exam fees. All fees are non-refundable.

Credit Card Payment <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover	Expiration Date	Check Payment <input type="checkbox"/> 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 your check is returned for any reason, you must submit 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 entry-level certificate to:

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

You may fax or email this application in advance of mailing BOC your entry-level certificate.

Email: cert@bocusa.org

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