



Certified Mastectomy Fitter (BOC CMF) Application

Personal Information			
First Name	Last Name	Middle Initial	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Street Address		Apartment Number	
City	State	Zip Code	Country
Email	Telephone Number		Mobile Number
Date of Birth (mm/dd/yyyy)	Social Security 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. <input type="checkbox"/> Please exclude me from the online BOC Practitioner and Facility Directory.			Date
Professional Information			
Current Professional Credentials (examples: BOCO, BOCP, COF, etc.)			
Company Name		Name of Immediate Supervisor	
Street Address		Suite Number	
City	State	Zip Code	Country
Telephone Number	Fax Number		Is this an accredited facility? <input type="checkbox"/> Yes <input type="checkbox"/> No
Patient Care and Experience Requirement			
I have a minimum of 120 hours (approximately 3 weeks of full-time work) of documented patient care. Please keep patient logs or a notarized letter of attestation from the certified practitioner or supervisor under whom you worked readily available. BOC performs random audits, and evidence of patient care must be available. Failure to document patient care hours may result in revocation of certification.			<input type="checkbox"/> Yes <input type="checkbox"/> No
I have included a copy of the certificate of attendance from a BOC-approved mastectomy fitter 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.

Applicant Signature

Exam Information

BOC's testing provider, **AMP**, will send you information for taking your examination by mail and email.

Certification Fees

Application (required)	\$ 50	Take your multiple-choice exam on any business day of the year (and some weekends, too). Plus, receive your results instantly as you walk out of the testing facility!	
Multiple Choice Exam	\$150		
PAYMENT AMOUNT	\$		
Credit Card Payment <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> American Express	Check Payment <input type="checkbox"/> Check (enclosed)	Check Number	
Credit Card Number	Security Code	Expiration Date	
Billing Address			
City	State	Zip 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 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. Applicants applying outside of the contiguous United States will be subject to an applicable surcharge for additional travel expenses. BOC does not offer refunds or accept post-dated checks.

You may email or fax this application and documentation to:

cert@bocusa.org
410.581.6228

Or, mail the completed application and documentation to:

Board of Certification/Accreditation
Attention: Certification Department
10461 Mill Run Circle, Suite 1250
Owings Mills, Maryland 21117