



BOARD OF ORTHOTISTS AND PROSTHETISTS
4052 Bald Cypress Way, Bin # C07
Tallahassee, Florida 32399-3257
850/245-4355

UPDATE SUPERVISOR FORM

**REGISTRATION IN AN
ORTHOTIC OR PROSTHETIC INTERNSHIP/RESIDENCY PROGRAM**

Please read these instructions and the laws governing the practice of orthotics and prosthetics before completing this form. Within 30 days receipt of this form, you will be sent a written status notice. **You can also visit the board's web site for additional information at www.doh.state.fl.us/mqa/OrthPros/index.html**

FORM PRPROCESSING:

No form is complete until all required documentation is received. Every question on this form must be answered. All documents and photos become a permanent part of your file and cannot be returned. You will be notified in writing if any additional documentation is required to complete this form. Forms are reviewed in date order received and **written** notice of the status will be sent to you at the mailing address you give in this form. The Board office must be notified **IMMEDIATELY** in writing of any changes to this form. Failure to do so could result in the denial of this form or revocation of licensure. **EXAMPLES:** change of address, employment, licensure status in another state, or an incorrect answer to a question. As a reminder to all applicants, please understand that Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete form shall expire one year after initial filing with the department.

MAILING ADDRESS:

List your complete mailing address, including street and apartment numbers and zip codes. The mailing address given in this form is where any correspondence from this office will be sent, including the permanent license. You can utilize a P.O. Box or practice mailing address in lieu of a home address if you want to avoid having your home address listed on the Web Site. If there is a change in your mailing address, you must submit any change **in writing**. Include in your letter your full name, your social security number, the complete new address and new telephone numbers.

FORM CHECKLIST

Use the following checklist to help ensure that you send in all necessary documentation for licensure in the State of Florida.

_____ 1. FORM.

- All questions answered on all required pages and if question not applicable, marked with N/A.
- All "YES" answers accompanied by an explanation or affidavit, as instructed.

_____ 2. PHOTO. Attach (1) 2"X2" photo to application. HEAD AND SHOULDERS ONLY.

_____ 3. ADDRESS. The correct mailing address is listed, in full. If there is ANY CHANGE IN ADDRESS during the application process, you must immediately notify the board office of any change in writing.

_____ 4. VERIFICATION(S) OF LICENSE IN ANOTHER STATE OR COUNTRY.

MAIL APPLICATION TO:

Board of Orthotists and Prosthetists
4052 Bald Cypress Way, Bin #C07
Tallahassee, Florida 32399-3257



CONFIDENTIAL AND EXEMPT FROM PUBLIC
RECORDS DISCLOSURE

Florida Department of Health
Board of Orthotists & Prosthetists

Name: _____
 Last First Middle

Social Security Number: _____

This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCS § 666 (a)(13). For all professions regulated under Chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.

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5. INTERN/RESIDENT REGISTRATION STATUS: (Attach additional sheets if necessary)

a. Do you now hold or have held a license or certificate of registration to practice any profession under Chapter 468, Part XIV, F.S., in any state, U.S. territory or foreign country? [] Yes [] No

If yes, list all such licenses/registrations

(State) (type of license) (license #) (status) (month/year of issuance)

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* Each state must complete the attached verification form and submit it directly to the Board office.

**6. UNDERGRADUATE AND GRADUATE EDUCATION INFORMATION: (Provide additional sheets if necessary)
Transcripts and/or certificates must be provided directly to the board office from institution**

Name and Location of Institution: _____ Dates of Attendance: _____

Number of Hours Completed: _____ Type of Degree Earned and Date Received: _____

Name and Location of Institution: _____ Dates of Attendance: _____

Number of Hours Completed: _____ Type of Degree Earned and Date Received: _____

7. Please provide an explanation in changing supervisor: _____

8. SUPERVISOR'S INFORMATION (To be completed by Intern/Resident Applicant's Supervisor)

Name of Supervisor: _____ Florida License # _____

Practice Location: _____
(Street Address) (Apt #)

(city) (State) (zip)

Telephone Number: (____) _____

Date Internship/Residency Starts: _____ Date Internship/Residency Ends: _____
Month/Day/Year Month/Day/Year

NOTE: Registration is not to exceed 2 years

I agree to supervise the referenced resident/intern in accordance to the requirements set forth in Rule 64B14-4.100(4) (a). I further agree that if this supervision is terminated for any reason, I shall inform the Board in writing within five (5) business days. At the conclusion of the supervision period I shall complete the Verification of Clinical Experience form confirming the completion of the training period. I will also include a detailed narrative of my work experience and reasons for early termination of supervision.

The above information is true and correct to the best of my knowledge.

(Signature of Supervisor)

(Date)

9. INTERN/RESIDENT AFFIRMATION

I agree to abide by the laws and rules of the state of Florida and to follow the direction of my supervisor in accordance to the requirements set forth by Rule 64B14-4.100(4) (a). I further agree that if this supervision is terminated for any reason, I shall inform the Board in writing within five (5) business days. I will also include a detailed narrative of my work experience and reasons for early termination of supervision.

I, _____, certify the above information is true and correct.
Print Name

Signature of Internship/Residency Applicant

Date