

8. Are you a current or former member of the U.S. Military or a spouse of a current or former member of the U.S. military? yes no
9. Has your license, certificate or registration ever been revoked, canceled, or suspended?
 yes no
10. If yes to the previous question, explain each disciplinary incident. _____

11. Have you ever been convicted of or plead guilty or nolo contendere to a felony? yes no
If yes, explain below for each.

12. Have you ever been sanctioned by either Medicare or Medicaid? yes no

If yes, give the date(s), each state or jurisdiction, and explain each below.

12. Place a checkmark by the type of **License or Permit** for which you are applying:

License

Permit

- | | |
|--|--|
| <input type="checkbox"/> (a) Orthotist | <input type="checkbox"/> (g) Temporary Orthotist |
| <input type="checkbox"/> (b) Prosthetist | <input type="checkbox"/> (h) Temporary Prosthetist |
| <input type="checkbox"/> (c) Pedorthist | <input type="checkbox"/> (i) Temporary Pedorthist |
| <input type="checkbox"/> (d) Orthotic Assistant | |
| <input type="checkbox"/> (e) Prosthetic Assistant | |
| <input type="checkbox"/> (f) Orthotic/Prosthetic Assistant | |

b. ASSISTANT LICENSURE EXPERIENCE INFORMATION

Three (3) years experience must be in fitting of custom orthotic or prosthetic devices.

Discipline of Application: Orthotics Prosthetics

Employer 1:

From: (mm/dd/yy) _____/_____/_____ To: (mm/dd/yy) _____/_____/_____

In the discipline of this application, list the hours worked per week: _____

Name of the facility for this period of employment:

Address _____

City

State

Zip Code

Telephone Number () _____ - _____

Direct Supervisor _____ Title _____

Employer 2:

From: (mm/dd/yy) _____/_____/_____ To: (mm/dd/yy) _____/_____/_____

In the discipline of this application, list the hours worked per week: _____

Name of the facility for this period of employment:

Address _____

City

State

Zip Code

Telephone Number () _____ - _____

Direct Supervisor _____ Title _____

Employer 3:

From: (mm/dd/yy) ____/____/____ To: (mm/dd/yy) ____/____/____

In the discipline of this application, list the hours worked per week: _____

Name of the facility for this period of employment:

Address _____

City

State

Zip Code

Telephone Number () _____ - _____

Direct Supervisor _____ Title _____

As an applicant for a Perfusionist license in Arkansas, I swear or affirm on oath and under penalty of Arkansas law the following:

____ I am a United States citizen or a legal permanent resident 18 years of age or older.

OR

____ I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act; I am 18 years of age or older; I am lawfully present in the United States; and my alien or admission number is: _____

(Print alien or admission number (required))

A **front and back copy of one** of the following documents must be attached:

1. Valid Foreign Passport with I-94; or
2. Temporary Resident Alien Card (I-688); or
3. Employment Authorization Card (I-766 or I-688B); or
4. Employment Authorization Document (I-688B); or
5. Refugee Travel Document (I-571)

Any experience with:

- upper extremity prosthetics lower extremity prosthetics

Give specific details of your experience:

Any experience with:

- lower extremity orthotics cervical orthotics
 upper extremity orthotics spinal orthotics

Give specific details of your experience:

Add additional information on back of this page as needed.

c. QUALIFYING DOCUMENTATION for Assistant Licensure

Attach written documentation from a licensed Orthotist or Prosthetist **acknowledging clinical skills** that the applicant **is qualified to perform** as an assistant in the field in which the person is seeking licensure as an assistant. Please include copy of license or board certification of licensed Orthotist or Prosthetist submitting the written documentation.

d. ACADEMIC INFORMATION- Complete 1-4 as applicable to your license requirements.

Orthotist & Prosthetist **Submit written evidence of:**

- Baccalaureate degree or completed semester hours equivalent to 4 years of study at a 4 year college or university and
- Completed Orthotic or Prosthetic education program accredited by the Commission on Accreditation of Allied Health Education Programs or its successor organization and
- Successful completion of a clinical NCOPE residency in Orthotics, Prosthetics or both
- ABCOPP certification.

Pedorthist **Submit written evidence of:**

- High school diploma or GED and
- Pedorthic education program
- ABCOPP certification.

Assistants **Submit written evidence of:**

- High school diploma or GED and
- Qualifying Documentation noted in b(c) on page 5.

1. Education Program _____

Location _____

Dates attended _____

2. Clinical Residency

Location _____

Dates attended _____

3. College or University _____

Location _____

Degree awarded and major field _____

Dates attended _____

College or University _____

Location _____

Degree awarded and major field _____

Dates attended _____

4. High School or GED

Location _____

Dates attended _____

II. NATIONAL CERTIFICATION:

American Board for Certification in Orthotics, Prosthetics & Pedorthics (ABCOPP)

Attach copies of Successful completion of ABCOPP certification examination:

Check each profession which you are Board Certificated:

- Orthotist
- Prosthetist
- Pedorthist

III. AFFIRMATION ON OATH

I declare that the information I have provided in this application is truthful. I understand that providing false information of any kind may: (a) void this application; and (b) may void any license or certificate issued to me based upon this application; and (c) may result in disciplinary action against me.

Date

Signature of Applicant

License Fees Please make check out to AR Dept. Health

License fee for initial licensure and renewal of licensure:

1. for the practice of Orthotics, Prosthetics, or Pedorthics, shall be three hundred dollars (**\$300**) every two (2) years;
2. for Orthotic Assistant, an Orthotic/Prosthetic Assistant or a Prosthetic Assistant shall be one hundred dollars (**\$100**) every two(2) years;
3. Late renewal \$100.00;
4. Reinstatement \$300.00;
5. Reinstatement for Assistant \$100.00.
6. All fees are non-refundable.
7. Applications **without** Fees & Required Information will be considered INCOMPLETE and will not be processed until all requested material is received.

Please make & keep a copy of the completed application & all requested information and **send original application, fee and all requested information to:**

Division of Health Facility Services address on first page.