



**Tennessee Board Of Podiatric Medical Examiners  
227 French Landing, Suite 300  
Heritage Place, MetroCenter  
Nashville, TN 37243  
www.Tennessee.gov/health  
(615) 532-5088 or (800) 778-4123, ext. 25088**

## **INSTRUCTIONS FOR LICENSURE AS AN ORTHOTISTS, PROSTHETISTS OR PEDORTHISTS**

The enclosed application and instructions are pertinent for those Orthotists, Prosthetists, and Pedorthists who are applying for licensure.

The requirements for application are supported by T.C.A. Sections 63-3-201 through 63-3-213 and Rules and Regulations Chapter 1155-4, which are included with the application packet.

It is suggested all documents listed in the instructions be requested from the appropriate institutions or individuals upon receipt of this package. All supporting documents must be received in the Board's administrative office by the time frames indicated in the instructions. Please allow ten (10) working days for the information submitted to be received and placed in your file. Mail delivered by Federal Express and other special courier services will be handled as routine mail.

## **METHODS OF LICENSURE**

The licensure method for individuals who have completed a orthotist education program accredited by the Commission on Accreditation of Allied Health Education Programs or its successor organization, and obtained a baccalaureate degree (or completed the number of semester hours equivalent to four (4) years of study at a four-year college or university) and who have successfully completed a clinical residency in orthotics and successfully completed all required examinations.

The licensure method for individuals who have completed a prosthetic education program accredited by the Commission on Accreditation of Allied Health Education Programs or its successor organization, and obtained a baccalaureate degree (or completed the number of semester hours equivalent to four (4) years of study at a four-year college or university) and who have successfully completed a clinical residency in prosthetics and successfully completed all required examinations.

The licensure method for individuals who possess a high school diploma or comparable credential approved by the Board and successfully completed a pedorthics education program accredited by the Board for Certification in Pedorthics, or a pedorthics education program approved by the board and who have successfully completed a qualified work experience program or internship in pedorthics in accordance with standards and procedures established by the Board, and successfully completed all required examinations.

# Instructions for Licensure

The following items must be submitted to the Board Office no later than thirty (30) days prior to the next scheduled board meeting.

## Procedures for Licensure as an Orthotist, Prosthetist, and Pedorthists

1. Completed application indicating type of requested licensure.
2. The application fee of three hundred and ten dollars \$310 non refundable (\$300 application fee and \$10 state regulatory fee).
3. One (1) passport style photograph taken within the last twelve (12) months.
4. Criminal background check information [click here](#) for instructions.

## SECTION I - Instructions for Licensure as an Orthotist and/or Prosthetist

5. Verification of successful completion of the following:

### Use Attachment 1

Certificate of completion of approved educational program in Orthotists/Prosthetists which is accredited by the Commission on Accreditation of Allied Health Education Programs or its successor organization; and

6. Verification of successful completion of the following:

### Use Attachment 2

Possess a baccalaureate degree (or have successfully completed the number of semester hours which is equivalent to four (4) years of study at a four-year college or university). The curriculum of the program of study completed by such person must include mathematics, physics, biology, chemistry, anatomy, biomechanics, pathology and psychology courses; and

7. Verification of successful completion of one of the following:

### Use Attachment 3

#### Orthotist

A clinical residency in orthotics. The majority of training must be devoted to services performed under the supervision of an orthotist licensed in Tennessee or a person in another state who has obtained certification from the American Board for Certification in Orthotics and Prosthetics, Inc. or the Board for Orthotist/Prosthetist Certification.

#### Prosthetist

A clinical residency in prosthetics. The majority of training must be devoted to services performed under the supervision of a prosthetist licensed in Tennessee or a person in another state who has obtained certification from the American Board for Certification in Orthotics and Prosthetics, Inc. or the Board for Orthotist/Prosthetist Certification.

8. Verification of Licensure in any other state:

**Use Attachment 5**

Verification of licensure - Complete the top portion of the verification of licensure form and send it to all states in which you hold a current license or have ever held a license. This form should be photocopied prior to signing it if it must be submitted to more than one (1) state.

9. An applicant for licensure as an orthotist, prosthetist, or pedorthist must successfully complete and make a passing score on the examination(s) approved and offered by the American Board for Certifications in Orthotics and Prosthetics, Inc., the Board for Certification in Pedorthics, or other examination(s) approved by the board.
10. Complete jurisprudence examination.

**SECTION II - Instructions for Licensure as a Pedorthist**

1. Possess a high school diploma or comparable credential approved by the Board; and
2. Verification of successful completion of the following:

**Use Attachment 1**

Successfully complete a pedorthics education program accredited by the Board of Certification in Pedorthics, or a pedorthics education program approved by the Board

3. Verification of completing the following:

**Use Attachment 4**

Successfully complete a qualified work experience program or internship in pedorthics:

4. Verification of Licensure in any other state:

**Use Attachment 5**

Verification of licensure - Complete the top portion of the verification of licensure form and send it to all states in which you hold a current license or have ever held a license. This form should be photocopied prior to signing it if it must be submitted to more than one (1) state.

5. An applicant for licensure as an orthotist, prosthetist, or pedorthist must successfully complete and make a passing score on the examination(s) approved and offered by the American Board for Certifications in Orthotics and Prosthetics, Inc., the Board for Certification in Pedorthics, or other examination(s) approved by the board.
6. Complete jurisprudence examination.

A completed file is one which contains ALL of the required documentation.

ATTACH  
PHOTO  
HERE



2217) 001 \$ 300  
2217) 006 \$ 10  
2218) 001 \$ 300  
2218) 006 \$ 10  
2219) 001 \$ 300  
2219) 006 \$ 10

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1 photo required

**APPLICATION FOR REGISTRATION AS A ORTHOTISTS, PROSTHETISTS, PEDORTHISTS  
(Must Type or Print)**

PLEASE CHECK ONE: \_\_\_\_\_ Orthotist \_\_\_\_\_ Prosthetist \_\_\_\_\_ Pedorthist

(You may only apply for one license per application. If you are credentialed for more than one of the three licenses listed above, you must submit a separate application and accompanying fee for each.)

**NOTE: ALL INFORMATION IN LICENSURE FILES ARE OPEN FOR PERSONAL INSPECTION BY ANY CITIZEN OF TENNESSEE PURSUANT TO TCA §10-7-503.**

FULL NAME: \_\_\_\_\_  
(Last) (First) (Middle) (Maiden)

MAILING ADDRESS: \_\_\_\_\_  
(Street and Number)

\_\_\_\_\_  
(City) (State) (Zip) (TN-County)

PHONE NUMBER: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

E-MAIL ADDRESS: Home \_\_\_\_\_ Work \_\_\_\_\_

PLACE OF BIRTH: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ SEX: M \_\_\_\_ F \_\_\_\_

You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. T.C.A. § 36-5-1301(a), as authorized by 42 U.S.C. § 405(c)(2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

PRACTICE ADDRESS IN TENNESSEE: \_\_\_\_\_

**EDUCATION:**

NAME OF SCHOOL DATES ATTENDED DEGREE

A. \_\_\_\_\_

B. \_\_\_\_\_

C. \_\_\_\_\_

**CLINICAL RESIDENCY IN ORTHOTICS OR PROSTETICS**

Are you currently enrolled in a Clinical Residency? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, Name of Residency: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Name of Supervisor: \_\_\_\_\_

License/Certificate No: \_\_\_\_\_ State where Licensed/Certified: \_\_\_\_\_

If seeking licensure by reciprocity are you currently certified in orthotics by either the American Board for Certification in Orthotics and Prosthetics, Inc. or the Board for Orthotist/Prosthetist Certification?  
Yes\* \_\_\_\_\_ No \_\_\_\_\_

Are you currently certified in prosthetics by either the American Board for Certification in Orthotics and Prosthetics, Inc. or the Board for Orthotist/Prosthetist Certification?  
Yes\* \_\_\_\_\_ No \_\_\_\_\_

Are you currently certified in pedorthics by the Board of Certification in Pedorthics, Inc., the American Board for Certification in Orthotics and Prosthetics, Inc. or Board for Orthotist/Prosthetist Certification?  
Yes\* \_\_\_\_\_ No \_\_\_\_\_

**\* If yes, please attach a copy of the current certificate(s).**

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers are in the affirmative with the exception of question number 1, please explain in detail on an attached sheet. In support of your explanation, the final documents or Orders from the states, courts, and agencies must be submitted as a part of your file.

	Yes	No
1. Are you now in good physical and mental health?	_____	_____
2. Has your certificate or license to practice Orthotists, Prosthetists or Pedorthists in any state ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, voluntarily surrendered, under threat of investigation or disciplinary action?	_____	_____
3. Do you have a medical condition which in any way impairs or limits your ability to practice orthotics/prosthetics/pedorthics with reasonable skill and safety? If yes, please explain.	_____	_____
4. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	_____	_____
5. Have you ever had a judgment rendered against you, or any legal action settled or pending, relating to the performance of your professional service?	_____	_____
6. Have you ever applied for a professional license in any health care profession and been denied or restricted for any reason?	_____	_____

Before signing this application, please read it again to make sure you have answered all questions accurately, completely, and clearly. Use additional sheets whenever necessary.

I, \_\_\_\_\_, solemnly swear that the statements on this application are true and correct. In signing this, I am aware that Chapter 9, Public Acts of 1947, provides that a person filing a forged Affidavit of Identification is subject to punishment prescribed by law for the crime of forgery.

I HEREBY:

SIGNIFY MY WILLINGNESS to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

AUTHORIZE THE BOARD, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

CONSENT TO THE RELEASE of such information.

RELEASE FROM LIABILITY the board, its staff, and all their representatives for their acts performed and statements made in good faith and without malice in connection with evaluating my application, my credentials, and my qualifications.

RELEASE FROM LIABILITY any and all organizations which provide information in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for licensure.

ACKNOWLEDGE THAT I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

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(Signature of Applicant)



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**CERTIFICATE OF COMPLETION OF APPROVED EDUCATIONAL  
 PROGRAM IN ORTHOTICS / PROSTETICS / PEDORTHICS**

This is to certify that \_\_\_\_\_, a participant of  
 (Applicant's Name)

\_\_\_\_\_, participated in an approved educational  
 program  
 (Name of Program)

offered by \_\_\_\_\_  
 (Name and Address of Facility)

from \_\_\_\_\_ thru \_\_\_\_\_ and that the above named participant successfully completed this program  
 (Date) (Date)

on \_\_\_\_\_.  
 (Date)

\_\_\_\_\_ was the program director for the participant named  
 above during the program indicated and that he/she has carefully read and completed this form and that the  
 statements made herein are strictly true in every respect. Verification of the program must be submitted on  
 your official letterhead.

\_\_\_\_\_  
 (Type or Print Name of Program Director)

\_\_\_\_\_  
 (Name of Program)

\_\_\_\_\_  
 (Street and Number)

\_\_\_\_\_  
 (City) (State) (Zip)

( ) \_\_\_\_\_  
 (Phone Number)

\_\_\_\_\_  
 (Signature of Program Director)

NOTE: Approved educational programs are those programs accredited by the Commission on Accreditation  
 of Allied Health Education Programs or its successor or a baccalaureate degree or number of semester  
 hours equivalent to four (4) years of study at a four-year college or university pursuant to Rule 1155-4-  
 .06(1)(b) and Rule 1155-4-.06(2)(b).

**ATTACHMENT 2**



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**TENNESSEE BOARD OF PODIATRIC MEDICAL EXAMINERS  
EDUCATION VERIFICATION**

**APPLICANT:** Supply the information requested and mail this entire form to the school at which you completed your baccalaureate degree ( or have successfully completed the number of semester hours which is equivalent to four (4) years of study at a four-year college or university). NOTE: Most schools require a fee, so you may want to contact the institution before mailing this form so that you can attach their fee.

**TO WHOM IT MAY CONCERN:**

I am applying for a Licensure to practice as a Orthotist/Prosthetist in the State of Tennessee. The Board of Podiatric Medical Examiners requires verification of my educational attainment. Please forward an original transcript bearing the institution's official seal to the Board's address below.

Applicant's Full Name: \_\_\_\_\_  
(Last) (First) (Middle/Maiden)

Applicant's Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Applicant's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Applicant's Student Identification Number: \_\_\_\_\_

Year of Graduation: \_\_\_\_\_

Degree Conferred: \_\_\_\_\_ Date Degree Conferred: \_\_\_\_\_

**Please forward an original graduate transcript bearing the institution's official seal to:**

**Tennessee Board of Podiatric Medical Examiners  
227 French Landing, Suite 300  
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Thank you for your cooperation and prompt response.

\_\_\_\_\_  
(Signature of Applicant)

\_\_\_\_\_  
(Date)



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VERIFICATION OF COMPLETION OF CLINICAL RESIDENCY
IN ORTHOTICS/PROSTHETICS

This form should be used to document supervision under a Tennessee licensed orthotist/prosthetist or if licensed in another state certification from the American Board for Certification in Orthotics and Prosthetics, Inc. or the Board for Orthotist/Prosthetist Certification.

TO BE COMPLETED BY APPLICANT:

(Name of Applicant)

(Social Security Number)

You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. T.C.A. § 36-5-1301(a), as authorized by 42 U.S.C. § 405(c)(2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

TO BE COMPLETED BY APPLICANT'S EMPLOYER:

I hereby certify that the above named has successfully completed a clinical residency in prosthetics/orthotics according to Rule 1155-4.06.

(Employer Name)

(Telephone Number)

(Address)

(License Number)

(Certificate Number)

Dates of the applicant's work experience:

(From: Month/Day/Year)

(To: Month/Day/Year)

(Signature)

(Title)

(Date)

**ATTACHMENT 4**



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**PROGRAM VERIFICATION OF COMPLETION OF A QUALIFIED WORK  
EXPERIENCE OR INTERNSHIP IN PEDORTHICS**

This form must be completed and signed by the supervising prosthetist, or podiatrist. This form must be mailed separately from the application and sent to the above address.

**TO BE COMPLETED BY APPLICANT:**

\_\_\_\_\_  
(Name of Applicant)

\_\_\_\_\_  
(Social Security Number)

You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. T.C.A. § 36-5-1301(a), as authorized by 42 U.S.C. § 405(c)(2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

\*\*\*\*\*

**TO BE COMPLETED BY APPLICANT'S EMPLOYER:**

I hereby certify that the above named has successfully completed a qualified work experience program or internship in pedorthics and shall be no less than sixty (60) hours of work experience. The continuous and actual presence of the supervisor within the physical confines of the practice location is required.

\_\_\_\_\_  
(Employer Name)

\_\_\_\_\_  
(Telephone Number)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(License Number)

\_\_\_\_\_

\_\_\_\_\_  
(Certificate Number)

Dates of the applicant's work experience: \_\_\_\_\_  
(From: Month/Day/Year)

\_\_\_\_\_  
(To: Month/Day/Year)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(Date)



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VERIFICATION OF LICENSURE

APPLICANT: Complete the TOP portion and forward to the Board of Podiatry in EACH state where you hold or have held a license to practice. (If you need more forms, make copies of this one). Some states require a fee be paid for providing clearance information. To expedite your application, you may wish to contact the applicable state(s) to determine if they require a fee for license verification.

\_\_\_\_\_ was granted \_\_\_\_\_ on \_\_\_\_\_
(Name of Applicant) (License Number) (Date)
by the state of \_\_\_\_\_. The Tennessee Board of Podiatric Medical Examiners requests that I submit evidence that my license in your state is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise, directly to:

Tennessee Board of Podiatric Medical Examiners
227 French Landing, Suite 300
Heritage Place MetroCenter
Nashville, TN 37243

\_\_\_\_\_ (Date) \_\_\_\_\_ (Signature)
\_\_\_\_\_ (Typed or Printed Name)

ADMINISTRATIVE OFFICE OF STATE PODIATRY BOARD. PLEASE COMPLETE:

\_\_\_\_\_ (License Number) \_\_\_\_\_ (Date Issued)

Basis of issuance:
National Board Exam
American Board for Certification in Orthotics and Prosthetics Exam \_\_\_\_\_ Score \_\_\_\_\_
Board for Certification in Pedorthics Exam \_\_\_\_\_ Score \_\_\_\_\_
Other \_\_\_\_\_ Explain \_\_\_\_\_

License currently registered? Yes \_\_\_ No \_\_\_
Derogatory information on file? Yes \_\_\_ No \_\_\_

If derogatory information in file please attach explanation, final orders, etc.

\_\_\_\_\_ (Date) \_\_\_\_\_ (Board Chair or Designated Official Print)
\_\_\_\_\_ (Board Chair or Designated Official Signature)
\_\_\_\_\_ (Title)

Board Seal