Alabama State Board of Prosthetists and Orthotists
Accreditation of Orthotic and/or Prosthetic Facilities

In accordance with **The Code of Alabama 1975 § 34-25A-1-14**, all facilities where prosthetic, orthotic, or prosthetic and orthotic care is provided to patients needing such care must submit an accreditation application with the Alabama State Board of Prosthetists and Orthotists. This form serves as the official application for accredited facilities. Please complete the following form in full; Forms must be accompanied by application fee and accreditation fee as well as all other required documentation or the form will be returned to the applicant for completion.

Date of Filing: _____

_____

Name of Facility Owner/Manager of Facility

_____ _____ _____

E-Mail of Contact Phone Number Fax Number

Main Branch Physical Address:

_____ _____ _____ _____ _____

Street Address Suite # City State Zip Code

Main Branch Mailing Address:

_____ _____ _____ _____ _____

Street Address Suite # City State Zip Code

_____

Compliance Officer Contact Number for Compliance Officer

(_____) (_____) (_____) (_____)

Medicare Medicaid Tax ID # NPI

_____

General liability, malpractice, product liability insurance carrier (**Please include a copy of the insurance certificate with application)**

Your facility accredited by: (please check one)

- ○ The Board of Certification/Accreditation, International -OR-
- ○ The American Board for Certification in Orthotics and Prosthetics

You must send a copy of accreditation documentation to the board with your application.

Please list all Satellite Offices below. You may make additional copies if needed.

Please list all licensed Orthotists, Prosthetists, Orthotists/Prosthetists, and Assistants practicing in the above facilities (use additional pages if needed). Each office must have a licensed practitioner-in-charge in each discipline for which service is provided to be a supervisor. The practitioner may supervise no more than 2 locations, provided they are no more than 35 miles apart:

Facility Office 1:

Supervisor of Orthotics	License #	Supervisor of Prosthetics	License #

Name of Orthotist/Prosthetist	License #	Name of Assistant	License #

Facility Office 2:

Supervisor of Orthotics	License #	Supervisor of Prosthetics	License #

Name of Orthotist/Prosthetist	License #	Name of Assistant	License #

Facility Office 3:

Supervisor of Orthotics	License #	Supervisor of Prosthetics	License #

Name of Orthotist/Prosthetist	License #	Name of Assistant	License #

Facility Office 4:

Supervisor of Orthotics	License #	Supervisor of Prosthetics	License #

Name of Orthotist/Prosthetist	License#	Name of Assistant	License #

Facility Office 5:

Supervisor of Orthotics _____ **License #** _____ **Supervisor of Prosthetics** _____ **License #** _____

Name of Orthotist/Prosthetist	**License #**	**Name of Assistant**	**License #**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

General Description of Offices:

Total Square feet of office: _____Number of Patient Fitting/Exam Rooms _____

Number of rooms with parallel bars: _____Number of chairs in patient waiting area_____

Please list all services provided in your facilities:
_____
_____
_____
_____
_____
_____

Patient Area Description:

Do all patient fitting rooms have doors, screens, or curtains: _____ Yes _____ No

Do patient chairs have armrests: _____ Yes _____ No

Do patient fitting rooms contain examination tables with disposable covers or readily disinfected surfaces: _____ Yes _____ No

Are protective gloves and disinfectants suitable for blood-borne and other pathogens are available and used in each patient are: _____ Yes _____ No

Are all patient rooms cleaned following each patient visit: _____ Yes _____ No

Laboratory Areas:
All laboratory equipment (machinery) meets OSHA requirements: _____ Yes _____ No
OSHA air quality standards are met: _____ Yes _____ No
Flammable materials are handled and stored according to OSHA and local regulations:
_____ Yes _____ No

Laboratory Areas:
Safety equipment is available and used at all appropriate times: _____ Yes _____ No

The facility has a safety manual and regular scheduled safety training for all employees:
_____ Yes _____ No

I declare the above information is true and correct to the best of my knowledge. I understand that providing false or misleading information in, with or concerning my license application may be cause for denial or loss of licensure. I understand that knowingly providing false information on a government document is punishable by a state jail felony. This form does not constitute licensure.

Name and Title of Person Signing: _____

Signature Date

THE STATE OF _____

COUNTY OF _____
BEFORE ME, the undersigned authority, on this day personally appeared _____ known to me to be the person whose name is subscribed to this instrument, and having been by me first sworn an oath, acknowledged that he or she had executed the same for the purposes and consideration therein expressed and that all statements are true and correct.

GIVEN under my hand and seal of office, this _____day of _____, _____. Notary

Public in and for _____County, _____ or _____

_____
Signature of Notary Seal of Notary

Fee:

Fully complete the form provided below. The Payment Remittance and fees must accompany the application and other required documents to be deemed complete. **The application fee is non-refundable**. Should accreditation be denied, full payment of other fees will be refunded.

Schedule of Fees:

Type of Accreditation Requested	**Fee**
Non-refundable Application Fee for Licensure	$150
License for Accredited Facilities (for each branch/satellite office)	$250

Payment Remittance

Name: _____

Social Security/ Tax ID #: _____

Address: _____

Number of branch offices (the license fee applies to each branch office)_____

Application Fee: _____

Accreditation Fee: _____

Total Amount Enclosed: _____

Alabama State Board of Prosthetists and Orthotists
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