

Application for the NBCOBT Orthopedic Brace Technologist Examination

Please read and sign all of the information requested below.
Mail to NBCOBT, 700 Beach Drive NE, Ste.103, 33701 or fax to 727-231-8385

Last Name: _____ First Name: _____

Home Mailing Address: _____

City/State/Province/Zip: _____

E-Mail Address: _____ Cell Phone :(____) _____

Work Phone :(____) _____ Fax Number: (____) _____

Highest Academic Level: (Circle One) High School 1 to 3 yrs college Bachelors Masters Doctorate

Primary Place of Employment: (Circle One) Hospital Private Practice Military Other: _____

Orthopedic Experience: (Circle One) 1 Year 2 Years 3-5 Years 6-10 Years +10 Years

Other Professional Certifications/Licenses? _____

Physician Verification: Physicians who specialize in orthopedics, ED and physical medicine can attest to the expertise of the applicant MUST complete this section. I certify that, to the best of my knowledge, the experience of the above individual as reported in this application is correct and complete. I further certify that the applicant has the necessary experience, skills and knowledge in applied orthopedic brace technology for OBT examination eligibility.

Name of Attesting Orthopedic Physician (Print)

Signature of Attesting Orthopedic Physician

Work Address:

City/State/Zip

I, _____, attest to the fact that I have fulfilled the eligibility requirements for NBCOBT Orthopedic Brace Technologist examination as stated, including necessary educational and/or work experience.

Signature of Applicant: _____ Date: _____

Fee: \$100.00 US Dollar/Funds ___ Free for current ASOP Members

Check/Money Order payable to "NBCOBT"

I HEARBY AUTHORIZE NBCOBT to charge the above amount to my: Visa MasterCard

Card Number: _____ Exp. Date: _____ CID #: _____ (3 digits)

Print Name Exactly as it appears on card: _____

Cardholder Signature: _____ Cardholder Phone :(____) _____

Cardholder Billing Address: _____

City/State/Zip