Application for the NBCOBT *Orthopedic Brace Technologist Examination*

Please read and sign all of the information requested below.
Mail to NBCOBT, PO Box 7440, Seminole, FL 33775 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 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 ____$50.00 for current ASOP ROT's
- ❑ 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