

For Office Use	License #:	Date Issued:	<input type="checkbox"/> \$400
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Application for Prosthetic Licensure

Iowa Department of Public Health/Bureau of Professional Licensure

PLEASE PRINT

Instructions are found on page 3

1. _____ 2. _____ 3. _____
First Name Middle Name Last Name
4. _____
Mailing Address
5. _____ 6. _____
City, State, Zip Code E-Mail Address
7. _____ 8. _____ 9. _____ -- --
*Daytime Phone (Including Area Code) Date of Birth Social Security Number**
10. Male Female 11. _____
Gender (optional question) If any of your documentation is in a name other than your current name, list the previous names of record.

The following questions must be answered. If you answer "Yes" to question #12 – #16 below, (1) attach a signed letter of explanation providing the details of the incident, (2) attach a copy of any court ordered evaluations, showing completion and recommendations, and (3) attach a copy of all official court documents regarding your conviction/malpractice suit, including final disposition and/or settlement. You must answer "Yes" even when a conviction or judgment has been deferred or expunged from your record.

12. Been convicted, found guilty of or entered a plea of guilty or no contest to a felony or misdemeanor crime (Other than minor traffic violations with fines under \$500)?	Yes	No
13. Had any judgments or settlements paid on your behalf as a result of a malpractice suit or claim against you?	Yes	No
14. Been investigated by a licensing, registration, or certification authority or organization; or had a licensing, registration, or certification authority or organization institute disciplinary action against you related to your professional practice? (If the investigation or action was instituted by this licensing board you may answer "NO" to this question).	Yes	No
15. Been disciplined or sanctioned by any licensing, registration, or certification authority or organization related to your professional practice? (If this licensing board took the disciplinary action, you may answer "NO" to this question).	Yes	No
16. Been engaged in illegal or improper use of drugs or other chemical mood altering substances? (If you are currently a participant in the Impaired Practitioner Review Committee, you may answer "NO" to this question.)	Yes	No

General Education:

17. _____ 18. _____
Name of College/University Graduation Date

Prosthetic Education

19. _____ 20. _____
Name of Professional Institution Degree Date

Residency:

21. Start Date: _____ End Date: _____

Name of Program _____

Endorsement:

22. Are you or have you ever been licensed, registered, or certified in another state?
If yes, list the two letter abbreviation of the state(s) below.

Yes No

I certify that I have carefully read the questions on this application and have answered them completely and truthfully. I declare under penalty of perjury that my answers, and all other statements or information submitted by me in this application process, are true and correct. If it is determined at any time that I have provided misleading or false information on or in support of this application, I understand that my application may be denied or that I may be subject to disciplinary action and criminal prosecution if I am already licensed.

I understand that I am required to update answers or information submitted herewith if the response or the information changes during the time period the application is pending. I also understand that this application is a public record in accordance with Iowa Code, Chapter 22 and that application information is public information, subject to the exceptions contained in Iowa law. Finally in submitting this application, I consent to any reasonable inquiry that may be necessary to verify the information I have provided on or in conjunction with this application.

I attest that I do not have a medical condition which impairs or limits my ability to practice my profession with reasonable skill and safety and understand that I must notify the Board should such a condition arise which impairs or limits my ability to practice my profession with reasonable skill and safety.

*This information is collected pursuant to Iowa Code Chapters 252J, 261 & 272C. Failure to provide mandatory information will result in license denial. **Privacy Act Notice:** Disclosure of your Social Security Number on this license application is required by 42 U.S.C. § 666(a)(13) and Iowa Code § 252J.8(1). The number will be used in connection with the collection of child support obligations and as an internal means to accurately identify licensees, and may be shared with taxing authorities as allowed by law including Iowa Code § 421.18.

27. _____
Applicant must sign here in ink

Date

An applicant who has been denied licensure by the board may appeal the denial and request a hearing on the issues related to licensure denial by serving a notice of appeal and request for hearing upon the Iowa board not more than 30 days following the date of mailing of the notification of licensure denial to the applicant. **Mail the original completed application bearing signature in ink to:**

**Iowa Board of Podiatry
Lucas State Office Building, 5th Floor
321 E. 12th Street
Des Moines, Iowa 50319-0075**

Prosthetist

Documentation Required for Licensure

- Application and fee (\$400). **All application fees are nonrefundable.** To apply, do one of the following:
 1. Create an account, apply and pay online at:
<https://ibplicense.iowa.gov/PublicPortal/Iowa/IBPL/common/index.jsp>, OR
 2. Print, complete and return a paper application with a check or money order payable to the Iowa Board of Podiatry:
<http://idph.iowa.gov/Portals/1/Files/Licensure/ProsthetistApp%20AMANDA%20No%20transition%20%282014%29.pdf>.

- Educational Requirements –
 1. Official academic transcripts verifying a Bachelor’s degree or higher from a regionally accredited college or university, sent directly to the Board office from the college or university.
 2. Official academic transcripts verifying proof of completion of an academic program in prosthetics accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP).

- Examination Requirement –

Official exam scores from the BOC or ABC prosthetics certification exam, sent directly to the Board office by the exam service.

- Residency Requirement –

Official statement from the program director indicating completion of a residency program approved by NCOPE. The statement must include the residency beginning and completion dates.

- Verification of licenses held in other states (if any):

- Applicants that have been previously licensed, registered or certified in any other state must provide official verification of licensure in the other state(s). The license verification must include license issue date, expiration date and any pending or past disciplinary action. The verification may be printed from another state licensing board’s website if it contains all of the required information. If web based verification is not available, the verification must be send directly to the Board office by the state(s) where the applicant has been licensed, registered, or certified. If the applicant has never been licensed in another state, ignore this item.