



# Facility Accreditation Application

**The American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc.**

PO Box 34862, Alexandria, Virginia 22334-0862 • (703) 836-7114 ext. 230 or 250 • Fax: (703) 836-0838

## SECTION I: Identification of Organization

Organization Name *(To be used on all identifying documents, including the certificate of accreditation. Please provide "dba" if appropriate.)*

Address 1

Address 2

City

State

Zip

( )  
Office Phone

( )  
Fax

Website

Email

**Geographic Service Area:**  Radius: (specify miles \_\_\_\_\_) **Federal Tax ID Number:** \_\_\_\_\_

**Applying For:** *(Check all that apply; see ABC Accreditation Guide Section II)* \_\_\_\_\_

### Orthotics

- Comprehensive
- Comprehensive Pedorthics
- Prefabricated
- Non-Custom Therapeutic Footwear
- Off-the-Shelf

### Prosthetics

- Comprehensive
- Mastectomy
- Ocular
- Ancillary Assistive Devices
- Durable Medical Equipment

## SECTION II: Ownership Information

Owner Name/Title *(List all. Please attach additional pages if necessary.)*

Address 1 *(If different than above)*

Address 2 *(If different than above)*

City

State

Zip

( )  
Office Phone

Ext

( )  
Fax

## SECTION III: Chief Executive Officer

Name/Title *(Name of individual to be contacted for further communication regarding this application and accreditation.)*

( )  
Office Phone

Ext

Email

## SECTION IV: Organization Contact Information

Chief administrative person responsible for location(s) seeking accreditation *(Name of individual to be contacted for further communication regarding this application and accreditation)*

( )  
Office Phone

Ext

Email

**SECTION V: Information on Locations** *(please see ABC Accreditation Guide Section IV for the affiliate location definition)*

**Primary Location**

Hospital    Medical Building    Retail Center    Free Standing    Other: (specify \_\_\_\_\_ )

Address 1

Address 2

City

State

Zip

Office Phone

Fax

Clinical Director

Office Manager

**Affiliate Location #1**

Hospital    Medical Building    Retail Center    Free Standing    Other: (specify \_\_\_\_\_ )

Distance From Primary Location: \_\_\_\_\_

Affiliate Facility Name *(To be used on all identifying documents, including the certificate of accreditation. Please provide "dba" if appropriate.)*

Address 1

Address 2

City

State

Zip

Office Phone

Fax

**Affiliate Location #2**

Hospital    Medical Building    Retail Center    Free Standing    Other: (specify \_\_\_\_\_ )

Distance From Primary Location: \_\_\_\_\_

Affiliate Facility Name *(To be used on all identifying documents, including the certificate of accreditation. Please provide "dba" if appropriate.)*

Address 1

Address 2

City

State

Zip

Office Phone

Fax

**If more space is required, please make additional copies of this page.**

**SECTION VI: Scope of Services**

- A. Please provide the following information for the primary location and each affiliate location. Please do not leave any boxes blank. Please make additional copies as needed.
- B. Applicant organizations must apply for ABC accreditation in all services it provides. Organizations must provide at least one Main Accreditation Service to be eligible for ABC accreditation.

	Primary Location	Affiliate Location #1	Affiliate Location #2
<b>Year Opened</b>			
<b>National Provider ID (NPI)</b>			
<b>CMS Supplier Number (PTAN)</b>			
<b>Days &amp; Hours of Operation</b>			
<p><b>Mark all services and items provided.</b>  <b>Do you rent any items indicated below?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Main Accreditation Services</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Orthoses: Custom Fabricated</li> <li><input type="checkbox"/> Orthoses: Custom Fit (non-custom fabricated)</li> <li><input type="checkbox"/> Orthoses: Off-The-Shelf (non-custom fit)</li> <li><input type="checkbox"/> Limb Prostheses</li> <li><input type="checkbox"/> Breast Prostheses and Accessories</li> <li><input type="checkbox"/> Facial Prostheses</li> <li><input type="checkbox"/> Ocular Prostheses</li> <li><input type="checkbox"/> Diabetic Shoes/Inserts (custom fabricated)</li> <li><input type="checkbox"/> Diabetic Shoes/Inserts (non-custom fabricated)</li> <li><input type="checkbox"/> Somatic Prostheses</li> </ul> <p><b>Durable Medical Equipment (DME) &amp; Ancillary Assistive Devices</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Automatic External Defibrillators (AEDs)</li> <li><input type="checkbox"/> Blood Glucose Monitors and Supplies (mail order)</li> <li><input type="checkbox"/> Blood Glucose Monitors and Supplies (non-mail order)</li> <li><input type="checkbox"/> Canes and Crutches</li> <li><input type="checkbox"/> Cochlear Implants</li> <li><input type="checkbox"/> Commodes/Urinals/Bedpans</li> <li><input type="checkbox"/> Continuous Passive Motion (CPM) Devices</li> <li><input type="checkbox"/> Continuous Positive Airway Pressure (CPAP) Devices</li> <li><input type="checkbox"/> Contracture Treatment Devices: Dynamic Splint</li> <li><input type="checkbox"/> Enteral Nutrients, Equipment and Supplies</li> <li><input type="checkbox"/> External Infusion Pumps and Supplies</li> <li><input type="checkbox"/> Gastric Suction Pumps</li> <li><input type="checkbox"/> Heat &amp; Cold Applications</li> <li><input type="checkbox"/> Hemodialysis Equipment and Supplies</li> <li><input type="checkbox"/> High Frequency Chest Wall Oscillation (HFCWO) Devices</li> <li><input type="checkbox"/> Home Dialysis Equipment and Supplies</li> <li><input type="checkbox"/> Hospital Beds-Electric</li> <li><input type="checkbox"/> Hospital Beds-Manual</li> <li><input type="checkbox"/> Implanted Infusion Pumps and Supplies</li> <li><input type="checkbox"/> Infrared Heating Pad Systems</li> <li><input type="checkbox"/> Insulin Infusion Pumps and Supplies</li> <li><input type="checkbox"/> Intermittent Positive Pressure Breathing (IPPB) Devices</li> <li><input type="checkbox"/> Intrapulmonary Percussive Ventilation Devices</li> <li><input type="checkbox"/> Invasive Mechanical Ventilation Devices</li> </ul>		<p><i>Durable Medical Equipment (DME) &amp; Ancillary Assistive Devices, continued...</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Mechanical In-Exsufflation Devices</li> <li><input type="checkbox"/> Nebulizer Equipment and Supplies</li> <li><input type="checkbox"/> Negative Pressure Wound Therapy Pumps and Supplies</li> <li><input type="checkbox"/> Neuromuscular Electrical Stimulators (NMES)</li> <li><input type="checkbox"/> Neurostimulators</li> <li><input type="checkbox"/> Osteogenesis Stimulators</li> <li><input type="checkbox"/> Ostomy Supplies</li> <li><input type="checkbox"/> Oxygen Equipment and Supplies</li> <li><input type="checkbox"/> Parenteral Nutrients, Equipment and Supplies</li> <li><input type="checkbox"/> Patient Lifts</li> <li><input type="checkbox"/> Pneumatic Compression Devices (lymphedema pumps)</li> <li><input type="checkbox"/> Power Operated Vehicles (scooters)</li> <li><input type="checkbox"/> Prosthetic Lenses: Conventional Contact Lenses</li> <li><input type="checkbox"/> Prosthetic Lenses: Conventional Eyeglasses</li> <li><input type="checkbox"/> Prosthetic Lenses: Prosthetic Cataract Lenses</li> <li><input type="checkbox"/> Respiratory Assist Devices</li> <li><input type="checkbox"/> Respiratory Suction Pumps</li> <li><input type="checkbox"/> Seat Lift Mechanisms</li> <li><input type="checkbox"/> Speech Generating Devices</li> <li><input type="checkbox"/> Support Surfaces: Pressure Reducing Beds/Mattresses/Pads</li> <li><input type="checkbox"/> Surgical Dressings</li> <li><input type="checkbox"/> Tracheostomy Care Supplies</li> <li><input type="checkbox"/> Tracheostomy Supplies</li> <li><input type="checkbox"/> Traction Equipment</li> <li><input type="checkbox"/> Transcutaneous Electrical Nerve Stimulators (TENS)</li> <li><input type="checkbox"/> Ultraviolet Light Devices</li> <li><input type="checkbox"/> Urological Supplies</li> <li><input type="checkbox"/> Ventilators Accessories/Supplies</li> <li><input type="checkbox"/> Voice Prosthetics</li> <li><input type="checkbox"/> Walkers</li> <li><input type="checkbox"/> Wheelchair Seating/Cushions</li> <li><input type="checkbox"/> Wheelchairs-Complex Rehab. Manual Chair</li> <li><input type="checkbox"/> Wheelchairs-Complex Rehab. Manual Chair Accessories</li> <li><input type="checkbox"/> Wheelchairs-Complex Rehab. Power Chair</li> <li><input type="checkbox"/> Wheelchairs-Complex Rehab. Power Chair Accessories</li> <li><input type="checkbox"/> Wheelchairs-Standard Manual</li> <li><input type="checkbox"/> Wheelchairs-Standard Manual Accessories</li> <li><input type="checkbox"/> Wheelchairs-Standard Power</li> <li><input type="checkbox"/> Wheelchairs-Standard Power Accessories</li> </ul>	

\* Please substitute current CMS Supplier Number if you have not yet been issued a NPI number.

**SECTION VI: Scope of Services** *(continued)*

**B. ORGANIZATIONAL PERSONNEL** *(Attach separate sheet if necessary)*

**Primary Location**

**Patient Care Supervisors:**

1. Name and Credentials	Position / Title
2. Name and Credentials	Position / Title
3. Name and Credentials	Position / Title

**Patient Care Providers and Technicians:**

1. Name and Credentials	Position / Title
2. Name and Credentials	Position / Title
3. Name and Credentials	Position / Title

**Affiliate Location #1**

**Patient Care Supervisors:**

1. Name and Credentials	Position / Title
2. Name and Credentials	Position / Title
3. Name and Credentials	Position / Title

**Patient Care Providers and Technicians:**

1. Name and Credentials	Position / Title
2. Name and Credentials	Position / Title
3. Name and Credentials	Position / Title

**Affiliate Location #2**

**Patient Care Supervisors:**

1. Name and Credentials	Position / Title
2. Name and Credentials	Position / Title
3. Name and Credentials	Position / Title

**Patient Care Providers and Technicians:**

1. Name and Credentials	Position / Title
2. Name and Credentials	Position / Title
3. Name and Credentials	Position / Title

**SECTION VII: Criminal History**

In an effort to better serve the public trust, ABC reserves the right to perform a criminal history background check and to deny an application or remove a credential based on the commission of a felony by the Applicant's owners or organizational personnel (as set forth in Section VI(B) of this application).

Answers to the following questions are mandatory. Failure to respond to each question will result in the application being returned. Failure to provide accurate, true and correct information shall constitute grounds for denial of your application, or removal of the credential.

- 1. Has any owner or organizational personnel of the Applicant ever been convicted of, or plead guilty or nolo contendere to a felony or a crime involving a patient? .....  Yes  No
  
- 2. Has any owner or organizational personnel of the Applicant ever been charged with a felony and plead guilty to, or been convicted of a lesser charge (e.g. misdemeanor)? .....  Yes  No
  
- 3. Has any owner or organizational personnel of the Applicant ever been charged with a felony which has yet to be dismissed? .....  Yes  No
  
- 4. Has any owner or organizational personnel of the Applicant ever been prohibited from doing business with any division of the federal government or is on the Office of the Inspector General's (OIG) exclusion list? . . .  Yes  No

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**If you answered "Yes" to any of the above questions, you must submit the following before your application will be considered complete:**

- 1. A complete written explanation of the circumstances surrounding the charge(s) that were filed against such individual, which includes a narrative describing:
  - a. A description of the incident.
  - b. Where the incident occurred.
  - c. The date the incident occurred.
  - d. The outcome of the charge(s) that were filed against the individual (e.g. verdict).
  - e. Any penalty/sentence associated with charges that have been filed against the individual.
  - f. When the sentence was or will be completed.
  - g. Court case headings regarding the incident.
  
- 2. Copies of court documents. If the documents are not available, indicate the jurisdiction in which the charge(s), conviction or plea occurred and why the documents are not available.

All application materials that are submitted remain confidential. The more information that you provide, the less time will be needed to review your eligibility status. If all the appropriate information is not provided, the processing of your application will be delayed and your application may be considered incomplete.

**SECTION VIII: Application Checklist**

Please note that the following items must be included with the submission of your application. If you have any questions regarding these items please contact ABC at (703) 836-7114, ext. 230 or 250.

- Business Associate Agreement
- Non Refundable Application Fee
- Copy of individual licenses (as applicable)

**SECTION IX: Terms of Agreement**

The undersigned organization (“Organization”) makes application to the The American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc. (ABC) for voluntary accreditation of the Organization and certifies that the information recorded in this application and attachments is true and correct. The Organization agrees, at all times, to provide information requested by ABC relevant to the review, evaluation and maintenance of the Organization’s accreditation status.

Information obtained or generated by ABC in the accreditation process is for the purpose of reviewing the professional service of, and the quality of care provided or arranged by, the Organization. ABC acknowledges that the information obtained or generated by ABC shall be considered confidential between the Organization and ABC, and shall be treated on a confidential basis, except as otherwise provided in ABC’s policies or as required by law, a court of law or a governmental agency. ABC will not take possession of any private health information about which it becomes aware during the course of ABC’s investigation of this application.

The Organization understands and agrees that it is solely responsible for being aware of and understanding ABC’s accreditation standards, which are readily available from ABC. The Organization agrees that, if accredited, it will remain in compliance with ABC’s accreditation standards and that failure to do so may result in loss of ABC accreditation status. The Organization is responsible for immediately being in compliance with existing, new and/or modified accreditation standards, as and when they are adopted by ABC from time-to-time.

The Organization agrees to abide by and be bound by the ABC Code of Professional Responsibility and the Rules and Procedures Regarding the Code of Professional Responsibility, and as they may be modified by ABC from time-to-time.

The Organization’s failure to abide by these terms and conditions may result in sanctions, including loss of accreditation status, against the Organization.

**Accepted By:**

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Name of Chief Executive Officer *(Please print)*

**X**

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Signature

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Date



# Business Associate Agreement

**The American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc.**

PO Box 34862, Alexandria, Virginia 22334-0862 • (703) 836-7114 ext. 230 or 250 • Fax: (703) 836-0838

**This Agreement** is made a part of the The American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc. ("ABC") Application for Accreditation (hereinafter, the "Underlying Agreement") submitted to ABC by \_\_\_\_\_ ("the Surveyed Organization"). The Underlying Agreement, when accepted by ABC, establishes the terms of the relationship between ABC and the Surveyed Organization.

Whereas, ABC and the Surveyed Organization are parties to the Underlying Agreement pursuant to which ABC provides certain accreditation survey and related services to the Surveyed Organization and, in connection with the provision of those services, the Surveyed Organization discloses to ABC certain Protected Health Information ("PHI," ) ( as defined in 45 C.F. R. §164.501) that is subject to protection under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");

Whereas, the Surveyed Organization is a "Covered Entity" as that term is defined in the HIPAA implementing regulations, 45 C.F.R. Part 160 and Part 164, Subparts A and E, the Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule");

Whereas, ABC, as a recipient of PHI from the Surveyed Organization, is a "Business Associate" as that term is defined in the Privacy Rule; Whereas, pursuant to the Privacy Rule, all Business Associates of Covered Entities must agree in writing to certain mandatory provisions regarding the use and disclosure of PHI; and

Whereas, the purpose of this Agreement is to comply with the requirements of the Privacy Rule, including, but not limited to, the Business Associate contract requirements at 45 C.F.R. §164.504(e).

**NOW, THEREFORE** in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

**1. Definitions.** Unless otherwise provided in this Agreement, capitalized terms have the same meanings as set forth in the Privacy Rule.

## **2. Scope of Use and Disclosure by ABC of Protected Health Information**

- A. ABC shall be permitted to use and disclose PHI that is disclosed to it by the Surveyed Organization as necessary to perform its obligations under the Underlying Agreement in accordance with ABC's established policies, procedures and requirements.
- B. Unless otherwise limited herein, in addition to any other uses and/or disclosures permitted or authorized by this Agreement or required by law, ABC may:
  - 1) use the PHI in its possession for its proper management and administration and to fulfill any legal responsibilities of ABC;
  - 2) disclose the PHI in its possession to a third party for the purpose of ABC's proper management and administration or to fulfill any legal responsibilities of ABC; provided, however, that the disclosures are required by law or ABC has received from the third party written assurances that (i) the information will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the third party; and (ii) the third party will notify the ABC of any instances of which it becomes aware in which the confidentiality of the information has been breached;
  - 3) aggregate the PHI with that of other Surveyed Organizations for the purpose of providing the Surveyed Organization with data analyses relating to the Health Care Operations of the Surveyed Organization. ABC may not disclose the PHI of one Surveyed Organizations to another Surveyed Organization without the written authorization of the Surveyed Organizations involved; and

4) de-identify any and all PHI created or received by ABC under this Agreement; provided, that the De-identification conforms to the requirements of the Privacy Rule.

**3. Obligations of ABC.** In connection with its use and disclosure of PHI, ABC agrees that it will:

- A. Use or further disclose PHI only as permitted or required by this Agreement or as required by law;
- B. Use reasonable and appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement;
- C. To the extent practicable, mitigate any harmful effect that is known to ABC of a use or disclosure of PHI by ABC in violation of this Agreement.
- D. Report to the Surveyed Organization any use or disclosure of PHI not provided for by this Agreement of which ABC becomes aware;
- E. Require contractors or agents to whom ABC provides PHI to agree to the same restrictions and conditions that apply to ABC pursuant to this Agreement
- F. Make available to the Secretary of Health and Human Services ABC's internal practices, books and records relating to the use and disclosure of PHI for purposes of determining the Surveyed Organization's compliance with the Privacy Rule, subject to any applicable legal privileges;
- G. Within (15) days of receiving a request from the Surveyed Organization, make available the information necessary for the Surveyed Organization to make an accounting of disclosures of PHI about an individual;
- H. Within ten (10) days of receiving a written request from the Surveyed Organization, make available PHI necessary for the Surveyed Organization to respond to individuals' requests for access to PHI about them that is not in the possession of the Surveyed Organization, in the event that the PHI in ABC's possession constitutes a Designated Record Set;
- I. Within fifteen (15) days of receiving a written request from the Surveyed Organization incorporate any amendments or corrections to the PHI in accordance with the Privacy Rule in the event that the PHI in ABC's possession constitutes a Designated Record Set.
- J. Not make any disclosure of PHI that the Surveyed Organization would be prohibited from making.
- K. In order to maintain the security of Surveyed Organization's patients' electronic protected health information (E-PHI), Business Associate agrees to:
  - 1) implement administrative, physical and technical safeguards required by the HIPAA Security rule;
  - 2) ensure its subcontractors also agree to implement these safeguards;
  - 3) report to the Surveyed Organization any security incident of which ABC becomes aware.

**4. Obligations of the Surveyed Organization.** The Surveyed Organization agrees that it:

- A. Has included, and will include, in the Surveyed Organization's Notice of Privacy Practices required by the Privacy Rule that the Surveyed Organization may disclose PHI for health care operations purposes;
- B. Has obtained, and will obtain, from Individuals consents, authorizations and other permissions necessary or required by laws applicable to the Surveyed Organization for ABC and the Surveyed Organization to fulfill their obligations under the Underlying Agreement and this Agreement;

- C. Will promptly notify ABC in writing of any restrictions on the use and disclosure of PHI about Individuals that the Surveyed Organization has agreed to that may affect ABC's ability to perform its obligations under the Underlying Agreement or this Agreement;
- D. Will promptly notify ABC in writing of any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes or revocation may affect ABC's ability to perform its obligations under the Underlying Agreement or this Agreement;

**5. Termination.**

- A. Termination for Breach. The Surveyed Organization may terminate this Agreement if the Surveyed Organization determines that ABC has breached a material term of this Agreement. Alternatively, the Surveyed Organization may choose to provide ABC with notice of the existence of an alleged material breach and afford ABC an opportunity to cure the alleged material breach. In the event ABC fails to cure the breach to the satisfaction of the Surveyed Organization, the Surveyed Organization may immediately thereafter terminate this Agreement.
- B. Automatic Termination. This Agreement will automatically terminate upon the termination or expiration of the Underlying Agreement.
- C. Effect of Termination.
  - 1) Termination of this Agreement will result in termination of the Underlying Agreement.
  - 2) Upon termination of this Agreement or the Underlying Agreement, ABC will return or destroy all PHI received from the surveyed organization or created or received by ABC on behalf of the Surveyed Organization that ABC still maintains and retain no copies of such PHI; provided that if such return or destruction is not feasible, ABC will extend the protections of this Agreement to the PHI and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

**6. Amendment.** ABC and the Surveyed Organization agree to take such action as is necessary to amend this Agreement from time to time as is necessary for the Surveyed Organization to comply with the requirements of the Privacy Rule.

**7. Survival.** The obligations of ABC under section 5.C. (b) of this Agreement shall survive any termination of this Agreement.

**8. No Third Party Beneficiaries.** Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

**Surveyed Organization**

**American Board for Certification in  
Orthotics, Prosthetics and Pedorthics, Inc.**

Signature: **X** \_\_\_\_\_

Signature: **X** \_\_\_\_\_

Name: \_\_\_\_\_  
*(Please print)*

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

# ABC Accreditation Application Payment Form

Organization Name (From page 1)

The following items must be included in your organization's application: Application for Accreditation; Business Associate Agreement; Non-refundable Application Fee.

**NOTE:** Due to the increased cost of surveying more complex businesses, organizations providing "DME" (See Section II in the "Accreditation Guide") are assessed a surcharge of **\$1,500 per survey day** for survey services. This fee is in addition to the fees calculated below.

Application & Survey Fees:	Fee	Total
<b>PRIMARY LOCATION</b> Main service, choose only one. <input type="checkbox"/> Comprehensive Orthotics & Prosthetics <input type="checkbox"/> Prefabricated Orthotics <input type="checkbox"/> Comprehensive Orthotics <input type="checkbox"/> Off-the-Shelf Orthotics <input type="checkbox"/> Comprehensive Prosthetics <input type="checkbox"/> Post-Mastectomy <input type="checkbox"/> Comprehensive Pedorthics <input type="checkbox"/> Non-Custom Therapeutic Footwear <input type="checkbox"/> Ocular Prosthetics	\$825.00	\$825.00
<b>Additional Service(s)</b> If applicable, check all that apply. <input type="checkbox"/> Comprehensive Pedorthics <input type="checkbox"/> Post-Mastectomy <input type="checkbox"/> Prefabricated Orthotics <input type="checkbox"/> Non-Custom Therapeutic Footwear <input type="checkbox"/> Off-the-Shelf Orthotics <input type="checkbox"/> Ancillary Assistive Devices	# of services selected: ____ X \$200.00 =	\$ _____
<b>AFFILIATE LOCATION #1</b> Main service, choose only one. <input type="checkbox"/> Comprehensive Orthotics & Prosthetics <input type="checkbox"/> Prefabricated Orthotics <input type="checkbox"/> Comprehensive Orthotics <input type="checkbox"/> Off-the-Shelf Orthotics <input type="checkbox"/> Comprehensive Prosthetics <input type="checkbox"/> Post-Mastectomy <input type="checkbox"/> Comprehensive Pedorthics <input type="checkbox"/> Non-Custom Therapeutic Footwear <input type="checkbox"/> Ocular Prosthetics	\$600.00	\$ _____
<b>Additional Service(s)</b> If applicable, check all that apply. <input type="checkbox"/> Comprehensive Pedorthics <input type="checkbox"/> Post-Mastectomy <input type="checkbox"/> Prefabricated Orthotics <input type="checkbox"/> Non-Custom Therapeutic Footwear <input type="checkbox"/> Off-the-Shelf Orthotics <input type="checkbox"/> Ancillary Assistive Devices	# of services selected: ____ X \$200.00 =	\$ _____
<b>AFFILIATE LOCATION #2</b> Main service, choose only one. <input type="checkbox"/> Comprehensive Orthotics & Prosthetics <input type="checkbox"/> Prefabricated Orthotics <input type="checkbox"/> Comprehensive Orthotics <input type="checkbox"/> Off-the-Shelf Orthotics <input type="checkbox"/> Comprehensive Prosthetics <input type="checkbox"/> Post-Mastectomy <input type="checkbox"/> Comprehensive Pedorthics <input type="checkbox"/> Non-Custom Therapeutic Footwear <input type="checkbox"/> Ocular Prosthetics	\$600.00	\$ _____
<b>Additional Service(s)</b> If applicable, check all that apply. <input type="checkbox"/> Comprehensive Pedorthics <input type="checkbox"/> Post-Mastectomy <input type="checkbox"/> Prefabricated Orthotics <input type="checkbox"/> Non-Custom Therapeutic Footwear <input type="checkbox"/> Off-the-Shelf Orthotics <input type="checkbox"/> Ancillary Assistive Devices	# of services selected: ____ X \$200.00 =	\$ _____
<b>DME</b> <input type="checkbox"/> I meet the requirements for DME. (See Section II in the "Accreditation Guide")	\$1,500.00	\$ _____
Payments may be tax deductible as business expenses. Please consult your tax advisor.	<b>Total Enclosed</b>	<b>\$ _____</b>

**Method of Payment:**

- Check # \_\_\_\_\_     
  Visa     
  MasterCard     
  American Express     
  Discover

Card Number

Expiration Date

Name on Card

**X**  
Signature

**Please mail application and forms to:**

American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc., PO Box 34862, Alexandria, VA 22334-0862  
 (703) 836-7114 ext. 230 or 250 • Fax: (703) 836-0838

Please note: The U.S. Postal Service is the only service that can deliver to a "PO Box" address.