Certified Practitioner Exam Registration Form

This form is to be completed by candidates who are retaking an exam or who have not registered previously for one of the three exams..

Please mail, fax or email registration form to:

American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc.
P.O. Box 34862, Alexandria, VA 22334-0862 • Fax: (703) 842-8516 Email: certification@abcop.org

GENERAL INFORMATION

Please complete the following:

Discipline of Application (**check one only**) ❑ Orthotics ❑ Prosthetics

_____

First Name Middle Name Last Name

(Your name must match your identification documents. When you are certified, your certificate will be printed as indicated here.)

Last four digits of your SSN: _____ Date of Birth: _____/_____/_____ *(MM/DD/YY)*

❑ Male ❑ Female

Home Address: _____

City: _____ State: _____ Zip: _____

Home Ph: _____ Personal Email: _____

Place of Employment: _____

Work Address: _____

City: _____ State: _____ Zip: _____

Work Ph: _____ Work Fax: _____

Work Email: _____

EXAM REGISTRATION & FEES

Please indicate the exam(s) and exam date for which you are applying:

Written and Written Simulation Exam Date	Application Deadline:
❑ May 7-12, 2018	March 1, 2018
❑ July 9-14, 2018	May 1, 2018
❑ September 17-22, 2018	July 1, 2018
❑ November 5-10, 2018	September 1, 2018

Fees:

❑ Written Exam $250
❑ Written Simulation Exam $250

Dates for the Clinical Patient Management (CPM): *(Candidates test one day only.)*

Exam Date/Location	Application Deadline:
❑ Orthotics: September 7-8, 2018 Tampa, FL	June 1, 2018
❑ Prosthetics: September 14-15, 2018 Tampa, FL	June 1, 2018

Fees:

❑ CPM exam $ 700

❑ **Please indicate if you require exam accommodations.** ABC offers reasonable and appropriate accommodations for those persons with documented disabilities, as required by the Americans with Disabilities Act (ADA). An additional application is required. *(Refer to the* ABC Practitioner Book of Rules & Candidate Guide *for more information and contact ABC for the required application.)*

IMPORTANT NOTES

All correspondence will be mailed to your home address and/or email address.

Upon submission of this form you may consider yourself registered for the exams indicated on this form, provided the following conditions have been met:

- ***the appropriate exam fee(s) have been remitted***
- ***you are within your three year eligibility period***
- ***you have not exhausted the allotted four attempts at any one exam***

If you must **cancel the exam date** you selected, ABC must receive written notice at least 31 days prior to the start of the exam cycle for you to be eligible for a refund of your exam fee.

If you fail to schedule an appointment with Prometric, you will forfeit your exam fee(s).

The exam fee(s) are required to register to retake the Certified Practitioner Exams.

The application fee is not required

ABC will only accept one application, per discipline, per exam date by the indicated application deadline for the exam date chosen. **Applications received after the application deadline will be subjected to a $75 late fee.**

By signing this registration form, you acknowledge that you have read this form and have complied with all instructions for exam registration. Further you acknowledge that you have read and will adhere to the cancellation/refund policy as outlined in the current ABC Practitioner Book of Rules & Candidate Guide.

Signature: _____ Date: _____/_____/_____
Sign Here (MM/DD/YY)

PAYMENT INFORMATION

Make checks payable to ABC.

Personal checks returned from your bank unpaid will cancel your registration. A $15 fee will be assessed for any check returned to ABC for any reason.

Your Name: _____

Method of Payment:

❑ Personal Check Enclosed - Name on Check: _____

❑ Company Check Enclosed - Name on Check: _____

Amount: $_____ Date of Check: _____/_____/_____ Check No.: _____
(MM/DD/YY)

❑ Money Order Enclosed

Amount: $_____ Date of Money Order: ____/____/____ Money Order No.: _____
(MM/DD/YY)

Credit Card: ❑ Visa ❑ MasterCard ❑ American Express ❑ Discover

Card No.: _____ Exp. Date: _____/_____
(MM/YYYY)

Cardholder Name: _____

Signature: _____Amount to be Charged: $_____

This registration form and fee must be received by the application deadline.

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Fax: (703) 842-8516

Please Note: The U.S. Postal Service is the only express service that can deliver to a P.O. Box. We recommend that you do not use certified mail.

QUESTIONS?
For questions about the application, eligibility or exam, contact ABC at 703-836-7114 ext. 221 or certification@abcop.org.