Therapeutic Shoe Fitter Competency Attestation

ATTESTER INSTRUCTIONS

To meet the eligibility criteria for ABC's Certified Fitter-therapeutic shoes credential, each candidate is required to possess the knowledges and demonstrate sufficient competence in the areas detailed on this attestation form. The attester must be one of the following: an ABC Certified Prosthetist Orthotist (CPO), an ABC Certified Orthotist (CO), an ABC Certified Pedorthist (C.Ped.), an ABC Certified Fitter-therapeutic shoes (CFts), or a professional referral source*.

**Professional referral source is defined as any appropriately licensed healthcare prescriber who is familiar with the applicant's professional knowledge and skills.*

NOTE: Please be advised that a **NO** answer in any of the Knowledge or Competency areas will prevent the application from being approved. The attester should address any areas that cannot be marked as **Yes** with the applicant prior to completing this Knowledge and Competency form.

Applicant's Name: _____

KNOWLEDGE AND COMPETENCY

Please complete the following related to the applicant's knowledge or competency in the following areas:

Does the applicant possess knowledge and understanding of:

Anatomy of the foot related to proper shoe fitting

❑ Yes ❑ No

Medical terminology as it relates to the provision of therapeutic shoes/inserts

❑ Yes ❑ No

Common foot pathologies and deformities

❑ Yes ❑ No

Patient evaluation techniques, including physical evaluation of the foot, skin/tissue evaluation, and identification of therapeutic shoe eligibility criteria

❑ Yes ❑ No

Measurement and fitting; including use of foot measurement tools, appropriate footwear selection for the diabetic foot, and shoe fitting

❑ Yes ❑ No

Materials and their properties specific to therapeutic footwear and prefabricated therapeutic inserts

❑ Yes ❑ No

Complications associated with the diabetic foot, including signs and symptoms and associated risk factors

❑ Yes ❑ No

Documentation requirements (eg., Medicare required documentation)

❑ Yes ❑ No

Practice Management (e.g., knowledge of reimbursement, patient confidentiality, federal and state rules, and regulations

❑ Yes ❑ No

Has the applicant demonstrated competency in:

Interviewing patients and communicating with referral sources

❑ Yes ❑ No

Taking a basic patient history and performing a physical exam (e.g., previous use of diabetic shoes, other health issues present, skin/tissue evaluation, edema assessment)

❑ Yes ❑ No

Managing patients relative to their diagnosis and condition

❑ Yes ❑ No

Measuring for therapeutic shoes/inserts

❑ Yes ❑ No

Assessing the fit and function of the therapeutic shoes/inserts at initial or diagnostic fitting, including safe heat molding of the prefabricated inserts

❑ Yes ❑ No

Assuring appropriate fit and function of the therapeutic shoes/inserts at final fitting and delivery

❑ Yes ❑ No

Appropriate documentation methods using established record-keeping techniques

❑ Yes ❑ No

Providing follow-up care (e.g., determine fit/function of shoes/inserts, patient compliance, change in patient's condition

❑ Yes ❑ No

Educating patients regarding safe usage, maintenance and hygiene issues related to therapeutic shoes/inserts

❑ Yes ❑ No

Use of universal precautions

❑ Yes ❑ No

ATTESTATION:

Applicant Name: _____

I attest that the applicant, in my opinion, possesses the moral character and professional standards required of ABC certificants. I further attest that the applicant has demonstrated knowledge and competency in all of the elements contained on this attestation form and is capable of performing the functions listed above that are required of a Certified Fitter-therapeutic shoes.

Your Name: _____

Your certification number: CPO: _____ CO: _____ C.Ped.: _____ CFts: _____

For Referral Source, Credential: _____

Are you in good standing with ABC, or your professional credentialing body? ❑ Yes ❑ No
(Good standing is defined as being current with annual renewal fees, complying with mandatory continuing education, and not currently under disciplinary sanction.)

Your current employer: _____

Daytime phone number: _____

Your employer during the period of this attestation: (if same, indicate same)

_____

Please indicate the time frame during which you supervised this applicant or have had familiarity of their knowledge and competency.

From: _____/_____/_____ to _____/_____/_____

Facility name and location: (If same, indicate same)

_____

Any act of falsification by the attester is a violation of the *ABC Code of Professional Responsibility* and shall be referred to the ABC Professional Discipline Committee or applicable credentialing body.

Signature of Attester: _____ Date: _____

All sections of this form must be complete.

This Knowledge and Competency form must be included with the Certified Fitter-therapeutic shoes application.

American Board for Certification in Orthotics, Prosthetics & Pedorthics, Inc.
330 John Carlyle St, Suite 210, Alexandria, VA 22314
Tel: (703) 836-7114 • Fax: (703) 836-0838 • info@abcop.org
abcop.org