

For Office Use	License #:	Date Issued:	<input type="checkbox"/> Paid
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## Application for Licensure

**Orthotist - \$600**

**Prosthetist - \$600**

**Prosthetist Orthotist - \$600**

**Pedorthist - \$400**

**Orthotist Assistant - \$300**

**Prosthetist Assistant - \$300**

**Fitter - \$300**

**2<sup>nd</sup> License - \$100**

**3<sup>rd</sup> License - \$100**

**Criminal Background Check - \$32**

The MN Board of Podiatric Medicine is seeking data from you which may be considered private or confidential under the MN Government Data Practices Act, Minn. Stat. §13.01 et seq. Minn. Stat. §13.04, subd. 2 requires the Board to notify you of the following four matters before you are asked to supply such information about yourself:

(1) This data is being collected to determine whether you meet the requirements for licensure as well as whether you have violated any statutes or rules the Board is empowered to enforce; (2) You are not legally required to provide this information, but failure to do so may result in the denial of this licensure application; (3) If you supply the data requested and it shows a violation of any of the statutes or rules enforced by the Board, you may be subject to disciplinary or other action by the Board. If you refuse to supply the data requested, your licensure application may be denied. In addition, falsification or omission of information may be used by the Board as a basis for disciplinary action; and (4) the data which you supply will be accessible to Board staff. The data you supply may also be released to other persons and/or governmental entities that have statutory authority to review the data, investigate specific conduct, and/or take appropriate legal action. If the Board institutes a formal disciplinary action against you, the information you supply could become public.

### PLEASE PRINT

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 Number (Include Area Code) Date of Birth Social Security*

10. ☐ Male ☐ Female 11. \_\_\_\_\_

*If any of your documentation is in a name other than your current name, list the previous names of record.*

12. Must meet certification requirements and are in good standing with:

- ☐ American Board for Certification in Orthotics, Prosthetics and Pedorthics
- ☐ Board of Certification/Accreditation

**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 the application are pending. 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.

The undersigned does hereby affirm that the statements contained in this application are true and correct.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary Public  
My commission expires:

Notary Seal or Stamp