

DO NOT WRITE IN THIS BOX: FOR OFFICE USE ONLY

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BC ☐ SCH ☐ DB ☐ CM ☐



2025 OTC® CERTIFICATION EXAMINATION APPLICATION

Orthopaedic Technologist Certified

TO BE USED ONLY FOR ELIGIBILITY ROUTE C
ATHLETIC TRAINERS ONLY

Return this ENTIRE Original SINGLE SIDED Completed Application Booklet (All 13 Pages)

DO NOT STAPLE ANY PART OF THIS APPLICATION

Mail FLAT To:
NBCOT Examinations
4736 Onondaga Blvd. #166
Syracuse, NY 13219-3304

www.nbcot.net
1-866-466-2268



The National Board for Certification of Orthopaedic Technologists, Inc. does not discriminate against any individual on the basis of race, color, religion, sex, national origin, age, disability, or any other characteristic protected by law.



Applications may take up to Fourteen (14) Business Days to validate, accept and process.

Revised Nov. 2024 to be used for 2025 Examinations Only

National Board for Certification of Orthopaedic Technologists, Inc.
 OTC® or OT-SC™ Certification Examination Non-Refundable
 Application Fee:

\$100.00

The following Applicants are required to include a **mandatory
 Non- Refundable \$100.00 Application fee** with any submission, as outlined below:

1. All **NEW Applicants** applying to take the OTC® or OT-SC™ Examination:
 (Definition: A candidate that has **never** taken the OTC® or OT-SC™ Examination before.)
2. **Any Applicant that is taking the OTC® or OT-SC™ Examination again.**
 (Definition: A candidate that has sat for, but did not pass the OTC® or OT-SC™ Examination and is retesting beyond six (6) months of his/her initial application).
3. **Applicants that have allowed their certification to lapse.**
 (Definition: One who had held the OTC® or OTC, OT-SC™ credential in the past, and as of the date of any upcoming examination does not).

The Application fee is separate from the Examination Testing Fee and must be included separate with the completed application at the time of submission.

Accepted forms of payment made payable in U.S. Dollars to NBCOT, Inc.

- U.S. Bank issued Cashier's Check, Official Check or Certified Bank Check.
- U.S. or Canadian Postal Money Order
- U.S. Bank issued Money order
- Official Hospital/Group or Corporate check

NO Personal Checks or Credit Cards are accepted for this Fee.

NOTE: If you are recertifying by Examination and your Certification has not lapsed or you are retesting within 6 months of your initial application or US Military Active Duty, you ARE NOT required to submit an application fee.

Attach your payment here

DO NOT TAPE OR STAPLE YOUR PAYMENT. ATTACH WITH PAPER CLIP

2025 Application for the NBCOT OTC®
Examination Must be completed in INK or on
Website and print MUST PRINT CLEARLY

Be sure you read and print a copy of the entire Application Instruction Book prior to completing this application for your records. Failure to provide all requested information will result in your application being RETURNED to you UNPROCESSED. All candidates are subject to a complete verification of documentation provided.

Today's Date: _____

Please check your status: ☐ New Applicant ☐ I plan on applying for ADA Accommodations

(Instructions and forms are found under "Applicants" within the General Exam Info. Tab on www.nbcot.net) Review Candidate Handbook for complete information on the needs and requirements for ADA Accommodations. ISO Quality will send a confirmation letter, which includes details of the special arrangements made if documentation is acceptable.

☐ Retesting Under what name did you previously take this exam? _____ Date of Last Attempt: _____

When would you like to take this Examination? ☐ February ☐ April ☐ June ☐ September ☐ November

Test Site **State** You Plan to Take Your Exam? _____

Legal Last Name: _____ Legal First Name: _____ Legal Middle Name: _____ Suffix: _____
 Jr., Sr., II, Etc.

(Required) Social Security #: _____ Date of Birth: _____
 Month/Day/Year

Physical Home Address: _____ Apt. Number: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Ext: _____ Fax Number: _____

E-MAIL Required for Registration – CANNOT USE EMPLOYER OR SCHOOL EMAIL ADDRESS. MUST PRINT CLEARLY

E-Mail Address: _____@_____

Mailing Address if Different from Physical Address. This is where all mail will be going to. **CAN NOT USE EMPLOYER ADDRESS:**

Home Mailing Address: _____ Apt. Number: _____

City, State, Zip: _____

Highest Academic Level: (Check ONLY One) **Proof of Degree MUST be submitted with application. (COPY ONLY)**

☐ Associates ☐ Bachelors ☐ Masters ☐ Doctorate

Primary Place of Employment (Check ONLY one): ☐ Hospital ☐ Private Practice ☐ Military

Experience in the care of orthopaedic patients (Check ONLY one): ☐ Under 2 Yrs. ☐ 2 Yrs. ☐ 3-5 Yrs. ☐ 6-10 Yrs. ☐ Over 10 Yrs.

Other Professional Certifications/Licenses you currently hold: _____

Attach copies of Certifications/Licenses

Eligibility Routes: Review Eligibility Route breakdowns and requirements found in the Application Instruction Book.

In order to qualify for the Orthopaedic Technologist Certified™ (OTC®) Certification Examination, an applicant must provide evidence that the OTC® certification eligibility requirements in this Policy have been met.

I. CERTIFICATION ELIGIBILITY ROUTE C.

An applicant must satisfy the requirements of Eligibility Route C to qualify for the OTC® Certification Examination. In its sole discretion, NBCOT, Inc. reserves the right to accept, reject, or request any additional information concerning, any information or material submitted by, or on behalf of, the applicant, in order to ensure conformity with the OTC® eligibility requirements in this Policy.

Eligibility Route C (Licensed or Certified Athletic Trainer Applicants):

The applicant has satisfied the following requirements:

1. Active certification as an Athletic Trainer (ATC) credentialed by the Board of Certification (BOC) of the National Athletic Trainer Association (NATA), or active State licensure as an Athletic Trainer.
2. **A minimum of six (6) months of full-time work experience, or 1,040 work hours, in orthopaedic technology, including work experience directly related to all current OTC® Certification Examination domains, completed within the twelve (12) months prior to the applicant's submission of the OTC® Examination Application; and,**
3. Direct supervision of the applicant by a licensed physician specializing in Musculoskeletal System during **all** Orthopaedic work experience.

Eligibility Route C Submission Requirements: To qualify for NBCOT, Inc. Eligibility Route C, a certification applicant must submit:

- A complete OTC Examination Application.
- A copy of his/her NATABOC ATC certification card or State license; and,
- A complete and accurate Physician Verification form from his/her supervising physician, confirming the applicant's completion of the work experience requirements.

OTC® CERTIFICATION.

An eligible applicant must complete and achieve a passing score on the current OTC® Certification Examination. NBCOT, Inc. reserves the exclusive right to void an applicant's test score based on a violation of an NBCOT, Inc. Policy or any other requirement.

ID Photos Requirements: **Items outlined in A & B below are REQUIRED.**

Failure to comply will result in your application being returned.

A. One (1) clear photocopy of your valid U.S Driver's License or valid U.S. Passport.

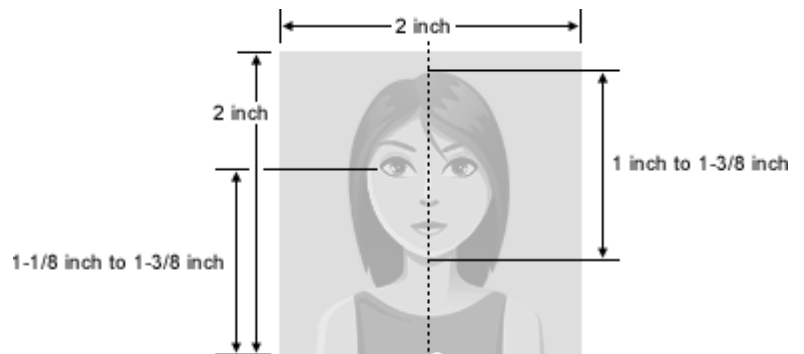
B. Two (2) Professionally taken Passport style color photos. MUST BE ON PHOTO PAPER. No Self taken photos accepted.

To identify the certificant and to issue an ID Certification, two (2) Passport type photos are required. ID Photos can be taken in your local area and need to be sent with rest of your documentation for processing. As you can see by the illustration given, ID Photos have certain requirements and must be professionally taken. When you have your ID photos you will receive **two** identical photos to submit. **Both photos** are to be sent in for processing. **Print and sign your name on the back of both photos.** Selfies or photos on regular paper will not be accepted.

PRINT NAME

Paper clip second photo to this page

USE NO STAPLES



Attach Passport Size Photo Here taped from back Do Not Staple or Tape over Photo.

For Use with Eligibility Route C - 2025
SUPERVISING PHYSICIAN ATTESTATION FORM

OTC APPLICANT®: Please complete this section ONLY

Print Applicant Name: _____

I authorize the physician completing this form to provide the National Board for Certification of Orthopaedic Technologists, Inc. (NBCOT, Inc.) with all information/documentation requested by NBCOT, Inc. related to my OTC® Examination Application and certification eligibility.

Applicant Signature: _____

Date _____

Supervising Physician: Please complete this section in its entirety

1. I _____, am a physician licensed in the State of _____, specializing in the musculoskeletal system.
2. I understand that the above-named individual is applying for Orthopaedic Technologist Certified™ (OTC®) Certification (applicant), and that, as part of his/her OTC® application, I am required to provide complete and accurate responses to the information identified in this Verification Form.
3. I attest and verify that the applicant satisfies the work experience requirements identified in Eligibility Route C of the NBCOT, Inc. Certification Eligibility Policy; specifically, that:
 - a. The applicant has a minimum of six (6) months of full-time work experience in orthopaedic technology, including work experience directly related to all current OTC® Certification Examination domains, namely Patient Assessment and Management, Office and Clinic Management, Casting, Splinting and Orthopaedic Appliances, Clinic and Hospital Surgical Procedures; and,
 - b. The applicant's work experience has been completed within the thirty-six (36) months prior to the applicant's submission of the OTC® Examination Application.
4. I am not aware of any information that raises a concern about the applicant's ability to provide orthopaedic technology services, or which would affect his/her eligibility for NBCOT, Inc. OTC® Certification.

 Signature of Supervising Physician

 Date

 License Number

 Telephone Number

I am currently employed with _____ (name of Group/Hospital), located at
 _____ (Address).

2025 SUPERVISING PHYSICIAN ATTESTATION FORM (Cont.)

NOTARY PUBLIC

(YOU ARE NOTARIZING THE PHYSICIAN SIGNATURE NOT THE APPLICANT)

State of _____ County of _____

On this _____ day of _____ in the year, before me, the undersigned notary public, personally appeared _____, (MD or DO) personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed above and acknowledged to me that s/he executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, executed the instrument.

WITNESS my hand and official seal

Notary Public

PLACE STAMP HERE

**NATIONAL BOARD FOR CERTIFICATION OF ORTHOPAEDIC TECHNOLOGISTS, Inc.
(NBCOT, Inc.)**

CERTIFICATION ELIGIBILITY POLICY

The National Board for Certification of Orthopaedic Technologists, Inc. (NBCOT, Inc.) requires that all NBCOT, Inc. applicants disclose any criminal, legal, or other disciplinary matters when applying for certification or within sixty (60) days of the occurrence of any such matter, unless otherwise specified by NBCOT, Inc. in writing.

NBCOT, Inc. has an obligation to carefully review and deny the certification, or renewal of any certification, consistent with this policy.

I. PRESUMPTIVE DENIAL

A. Criminal Matters (convictions, guilty pleas, or deferred adjudications)

Applications for certification from individuals who have been convicted of serious crimes will not be accepted for certification or renewal. Specifically, crimes involving the following circumstances will presumptively disqualify a candidate for certification or recertification unless: there are significant and extraordinary circumstances supporting certification or renewal; a period often (10) years has elapsed since the completion of all court-ordered requirements; and, significant rehabilitative actions have been taken by the applicant or certificant. Submissions regarding circumstances, rehabilitative actions, etc., will be considered in context of NBCOT, Inc. policies and procedures.

1. Crimes involving death, physical harm, or the threat of physical harm to another person (e.g., murder, aggravated assault, domestic violence, assault, battery, communicating threats).
2. Sexual crimes (e.g., rape, indecent assault).
3. Crimes involving the abuse of children, the elderly, or individuals of diminished mental or physical capacity.
4. Crimes involving intimidation, harassment, involuntary enslavement or restraint (e.g., hate crimes, terroristic threats, kidnapping, human trafficking).
5. Crimes against the property of others, or involving the deception of others (e.g., theft, arson, embezzlement, forgery, fraud).
6. Crimes involving the manufacture or distribution of controlled, dangerous substances.
7. Crimes involving possession of a schedule I or II controlled substance (e.g., heroin, cocaine, oxycodone).
8. Multiple offenses of driving under the influence/driving while ability impaired.

B. Submission of Inaccurate or False Application Information

Applications for certification from individuals who have submitted inaccurate or false information to NBCOT, Inc. in connection with his or her application will not be accepted for certification or renewal.

Applicants for certification who submit false information will be considered ineligible for certification for a minimum period of five (5) years. Following this time period, applicants may submit for consideration written documentation of how prior unprofessional behavior has been addressed and resolved. Such submissions will be considered in accordance with established NBCOT, Inc. policies and procedures.

II. OTHER MATTERS

Applications for certification or renewal also may not be accepted when the individual has been convicted, entered a plea agreement, or deferred adjudication relating to criminal matter(s); has been the subject of any governmental or professional disciplinary matter; or, has been named as a defendant in a civil litigation relating to his or her professional services or activities. The following criteria will be considered in determining whether an applicant or certificant involved in such a matter is eligible for NBCOT, Inc. Certification.

1. The seriousness of the disclosed matter.
2. The relationship of the disclosed matter to the applicant's or certificants professional activities or ethical responsibilities.
3. The amount of time that has passed since the matter occurred.
4. The completion of any court, agency or organizational conditions or requirements including parole.
5. The amount of time that has passed since the completion of all court, agency or organizational conditions and requirements.
6. Whether certification of the individual would negatively affect the public's trust of the NBCOT, Inc. certification.

III. GENERAL PROCESS

Certification eligibility determinations will be communicated to the applicant or certificant in writing. Application fees will not be refunded for certification applications that are rejected by NBCOT, Inc. pursuant to this Policy.

My signature attests that I acknowledge and understand pages 8 & 9

Today's Date: _____

Print Name: _____

Signature: _____

2025 7.4 Applicant Ethics Representations and Agreements

Read Carefully and Circle One Choice

1. I **agree** to act, and conduct my Orthopaedic Technology services and activities, consistent with the current NBCOT Code of Ethics, NBCOT Ethics Case Procedures, and other applicable NBCOT Certification Program Policies, and as they may be amended or revised.

YES NO
2. I have **not been**, nor am I **currently**, the subject of any charge, complaint, or conviction related to a criminal matter, military court matter, or other court matter that involves a jail sentence (Imprisonment).
YES NO
3. I have **not been**, nor am I **currently**, the subject of any formal complaint or charge by a government or other regulatory body, professional association, or certifying organization.
YES NO
4. I have **not been** found in violation of any law, regulation, or policy by a Government or other regulatory body, professional association, or certifying organization.
YES NO
5. I have **not been**, nor am I **currently**, the subject of any other court or Governmental matter or proceeding, related to my professional practice or business activities.
YES NO
6. I understand that any intentional or unintentional failure to provide timely, accurate, and complete responses to this application may result in sanctions by the NBCOT, Inc. Certification Program.
YES NO

If you answered **“NO”** to any question(s) above, you must provide a complete, detailed explanation of the circumstances related to your **“NO”** response. The final disposition and/or decree related to any matters included in items 2,3,4 or 5, above must be provided.

Place these materials in a sealed envelope marked **“ETHICS”** and attach the envelope to your application. Failure to include the required information may delay the processing of your application.

Today's Date: _____

Print Name: _____

Signature: _____

2025 PRIVACY STATEMENT

Your Certification status is a matter of Public Record, and therefore is not covered in the Opt In/Opt Out Choices below.

The National Board for Certification of Orthopaedic Technologists, Inc. (NBCOT, Inc.) does not arbitrarily share personal and confidential information regarding its credential holders unless express permission has been given to the NBCOT, Inc. or is required under law.

For the purposes below the NBCOT, Inc. will only release your name, email and mailing address information. Your choice does not apply to any emails or US mail from the NBCOT, Inc.

Please choose one option below to be applied to your record, which you may change at any time. (If both options are checked you will be listed as an Opt IN).

- The **NBCOT, Inc.** may receive requests from Orthopaedic State Associations, Orthopaedic/Surgical Companies and/or NBCOT Partnership Program Vendors to provide them with our list of Certified Orthopaedic Technologists to be used for educational opportunity notification or vendor purposes.
- The **NBCOT, Inc.** will not release your name, your physical mailing address, e-mail address or any contact information to be used for educational opportunity notification or vendor purposes.

Please check only one option.

☐

Yes. The NBCOT, Inc. may release my information to all parties listed above.

☐

NO. DO NOT RELEASE ANY INFORMATION. This does NOT include correspondence originating from the NBCOT, Inc.

I instruct the National Board for Certification of Orthopaedic Technologists, Inc., to treat all of my personal information on file as confidential for the purposes listed above.

To change your choice at any time, please visit www.nbcot.net and go to "Credential Holders" tab then click Important Information link.

Today's Date: _____

Print Name: _____

Signature: _____

2025 Applicant Attestation Section:

By submitting this exam application, you are attesting to having read and understood the following National Board for Certification of Orthopaedic Technologists, Inc. Certificant Attestation Statement and the information provided in the National Board for Certification of Orthopaedic Technologists, Inc. Certification Application Instruction Book.

Please read this statement carefully.

I attest that I am of legal age.

I have read, understand, and agree to adhere to the provisions of the current National Board for Certification of Orthopaedic Technologists, Inc. Certification Candidate Examination Handbook, Code of Ethics and Standards of Practice, all of which can also be found on the website at www.nbcot.net. By signing below, I am attesting that I have personally completed the exam application and that the information I submit in the application myself and in any required accompanying or subsequent documentation is true and accurate to the best of my knowledge. I also have included all documentation, photo and ID requirements listed within the application

Additionally, I understand that persons who apply for certification as an ORTHOPAEDIC TECHNOLOGIST OTC® or ORTHOPAEDIC TECHNOLOGIST–SURGERY CERTIFIED OT-SC™ or persons who have been certified by the National Board for Certification of Orthopaedic Technologists, Inc., are subject to the Code of Ethics and the Procedures and Standards.

I understand that the National Board for Certification of Orthopaedic Technologists, Inc. may amend its requirements, policies, and procedures for initial certification, certification renewal, and Procedures for Enforcement of the Code of Ethics. During my six-year certification cycle, I agree to notify the National Board for Certification of Orthopaedic Technologists, Inc. in writing within 30 (thirty) days of any violation of the Code of Ethics, specifically as it refers to Item 7.4 “Applicant Ethics Representations and Agreements” which can be found within this Examination Application.

I agree to hold the National Board for Certification of Orthopaedic Technologists, Inc., its directors, officers, employees, and agents free from any damage or complaint by reason of any action taken in connection with the score or score given with respect to this or any other National Board for Certification of Orthopaedic Technologists, Inc. certification examination, or the failure of National Board for Certification of Orthopaedic Technologists, Inc. to issue me certification.

I understand that if it is confirmed that I was not eligible at the time I took the examination; my examination score may be voided. If it is ever determined that I was a participant in any testing irregularity, such as use of any electronic device during the examination and/or break, or cheating, to include discussing, transmitting or copying a test item(s) or answer(s) to a third-party, before, during or after the examination, my certification or eligibility status with the National Board for Certification of Orthopaedic Technologists, Inc. may be changed, and I may be subject to disciplinary and/or legal action.

Further, I understand that if I need to file an examination administrative or technical complaint that I must file such a complaint on-site at the IQT Test Center on the day of my examination.

I also agree to notify National Board for Certification of Orthopaedic Technologists, Inc. in writing of any address and/or name change within thirty days (30) after the change becomes effective to remain in compliance. No verification of my credential will be provided if I am not in compliance.

If requested to do so, the National Board for Certification of Orthopaedic Technologists, Inc. may verify my certification status. I hereby give consent to the National Board for Certification of Orthopaedic Technologists, Inc. to release my certification status to any academic institution, employer, regulatory agency, legal entity, or other party that may inquire.

Today's Date: _____

Print name here: _____

Signature: _____

Examination Payment Section:

☐ Examination Fee: \$450.00 U.S. Currency.

☐ \$100.00 Late Fee for applications received after deadline is included. **This fee is non-refundable.**

Total Examination Fee Enclosed: \$ _____

☐ U.S. or Canadian Postal Money Order made payable to NBCOT, Inc.

☐ U.S. Bank/Corporate Check or U.S issued Money Order made payable to NBCOT, Inc.

(No Personal Checks Accepted. The application will be returned unprocessed. \$40.00 will be charged for any returned funds by your bank.)

If paying with a credit card: There will be a 3% surcharge for all credit card transactions.

☐ Credit Card Examination Fee: \$463.50

☐ Credit Card Late Fee for applications received after the deadline (Non-Refundable) \$103.00

Total Examination Fee Enclosed: \$ _____

Be sure to complete all sections below with Cardholder Signature

If this is **NOT YOUR** credit card, the card holder will be contacted for authorization for this charge.

I HEARBY AUTHORIZE THE NBCOT TO CHARGE THE ABOVE AMOUNT TO MY U.S. ISSUED:

☐ Visa® ☐ MasterCard®

Credit Card Number: _____ - _____ - _____ - _____

Exp. Date: _____ CID #: _____ (Last 3 digits found on the back of your card)

Print Name Exactly as it is on card: _____

Cardholder Signature: _____

Cardholder Phone Number: _____

Cardholder Mailing Address: _____

City State Zip Card

Billing Address: (Where your bill is received)

City State Zip

2025 OTC® CERTIFICATION EXAMINATION APPLICATION CHECK LIST

- ☐ I have read the “Examination Candidate Handbook” and I completely understand it.
- ☐ I have printed, signed, and dated all pages that require MY signature and attention.
- ☐ I have checked the boxes on the "Ethics Page" to address item 7.4 within the “Code of Ethics” and provided my signature. If I answered **No** to any issues, I have sent my declaration of charges with a written explanation of all charges in my own words. **COPIES OF ALL COURT DOCUMENTS (final decree of charges and/or dismissal papers showing all fees paid) HAVE BEEN INCLUDED.**
- ☐ Privacy Statement is understood and my “Option” is checked.
- ☐ The “Physician Verification” statement is complete, with his/her signature present and **NOTARIZED**. There is **NO EXCEPTION** to this. Even if you are recertifying. The signature **MUST BE** a Licensed Physician only. (MD, DO). **There are NO exceptions to this.**
- ☐ I have enclosed **ALL** supporting documentation that is required for the eligibility route I am applying under.
- ☐ I have enclosed a clear color photocopy of my Photo ID. (Valid U.S Driver’s License or U.S. Passport)
- ☐ I have enclosed **TWO (2)** clear color passport type photos. One (1) attached to page 5 and enclosed a second photo with the application. These photos must be professionally taken.
- ☐ I have enclosed the mandatory \$100.00 application fee (If applicable)
NO PERSONAL CHECKS OR CREDIT CARDS ACCEPTED FOR THIS FEE.
- ☐ I have enclosed the proper testing fee (s) (NO PERSONAL CHECKS) made payable to the National Board for Certification of Orthopaedic Technologists (NBCOT, Inc.). (If you know that your application will be **RECEIVED** after the posted deadline, you must include the late filing fee of \$100.00. **Any submission received without the proper fees enclosed will be returned unprocessed.**
- ☐ I have made a copy of all documents being submitted for my records.
- ☐ I am mailing this entire **ORIGINAL SINGLE SIDED** “Examination Application” including cover page **FLAT**, NOT a photocopy to: (MISSING PAGES OR APPLICATIONS THAT ARE TWO SIDED/DOUBLE SIDED COPIES WILL RESULT IN THE RETURN OF YOUR APPLICATION).

NBCOT Examinations

National Board for Certification of Orthopaedic Technologists, Inc.

4736 Onondaga Blvd. #166

Syracuse, NY 13219-3304

Applications MUST be mailed FLAT and SINGLE SIDED. Nothing can be emailed or faxed.

USE NO STAPLES ON THIS APPLICATION OR SUPPORTING DOCUMENTATION.