National Board For Certification of Orthopaedic Technologists, Inc.

Letter Verification of Certification Request Form

Mail to: NBCOT Verification Dept., 4736 Onondaga Blvd #166, Syracuse, NY 13219

To request a Certified Stamped letter verifying an OTC® or OT-SC™ Certification, complete this form. Please **Print Clearly** or **Type** your request. Your letter will include; the Credential Holder's legal name, Certification number, day-month-year they were certified, day-month-year they are certified through (renewal date), and their status as either an OTC® or as an OT-SC™. The letter will include any disciplinary actions on file. This letter is only processed if the person you are inquiring about is currently certified. We do not verify lapsed certification requests. We do not report exam scores**. Questions regarding all verifications should be directed to our office at (855) 476-7677 or Email: executivedirector@nbcot.net.**

Please allow **ten (10) business days** to receive your letter by US Mail. All information provided is secure and required to be provided in order to have your request processed. Missing information will void this form.

Date of Your Request:_____ **Number of Letters requested:** _____**@ $30.00ea.**

Certificate Number presented to you: _____-_____.

Circle one: ☐ **OTC®** ☐ **OT-SC™** ☐ **Both**

Current LEGAL name of Credential Holder: _____

Current HOME Address of Credential Holder:

_____

City:_____ **State**: _____ **Zip Code:**_____

Current Home Phone: (_____**)** _____-_____ **Daytime Phone:(**_____**)** _____-_____

Last 4 digits of Credential Holder's Social Security Number:_____**(REQUIRED)**

Circle one to receive verification request. : State Board Employer Credentialing Agency

Print Your Name:_____

Your Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Your Telephone: (_____) _____-_____ Ext._____

Your Email Address:_____@_____

Method of Payment: **$30.00 per** **Bank Check** ☐ **Group/Hospital Check** ☐ **Credit Card** ☐

Charge to: ◯ **Visa** ◯ **MasterCard** **We do not accept AMEX or Discover Card or Personal Checks**

Print Name on Card: _____

Credit Card Number: _____-_____-_____-_____

Expiration Date: **Month**_____ **Day**_____ **Year**_____

Last 3 digits on back of Card: _____

Amount of Credit Card Charge: $_____

CARD HOLDER Signature:_____
(Required for Credit Card Requests)

Credit Card Billing Address:_____
(Where you receive the bill for above card)

City: _____ **State:** _____ **Zip:** _____

Telephone Number Associated with Credit Card: (_____**)** _____-_____.