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OT-SC™ EXAMINATION APPLICATION

Orthopaedic Technologist - Surgery Certified

TO BE USED FOR INITIAL, RECERTIFICATION OR LAPSED OT-SC™ CREDENTIAL

Return this ENTIRE Original SINGLE SIDED Completed Application Booklet (All 14 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 nbcot_office@nbcot.net



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 process.

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

\$85.00

The following Applicants are required to include a **mandatory Non- Refundable \$85.00 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).

This 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 in U.S Dollars, made payable to NBCOT, Inc.

Please note that no Personal Checks or credit cards are accepted for this Fee.

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

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

Attach your payment here

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

2024 Application for the NBCOT OT-SC™ Examination

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: Check one only

New Applicant OTC Number: ____ - ____

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: _____

Recertifying (currently certified) OTC® #: _____ - _____

Lapsed (Certification no longer current) What year did your certification lapse?

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

What **STATE** do 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 ACCEPT 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) Must have a minimum of a High School Diploma.

Proof of Degree beyond a High School Diploma MUST be submitted with application.

GED/High School 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): 2 Years 3-5 Years 6-10 Years Over 10 Years

Other Professional Certifications/Licenses you currently hold: _____

Attach copies of Certifications/Licenses

Eligibility Route: A candidate must be a current OTC® with a minimum of 1-year surgical experience in Orthopaedics. The OT-SC™ must maintain the OTC® Certification to maintain the OT-SC™ Certification.

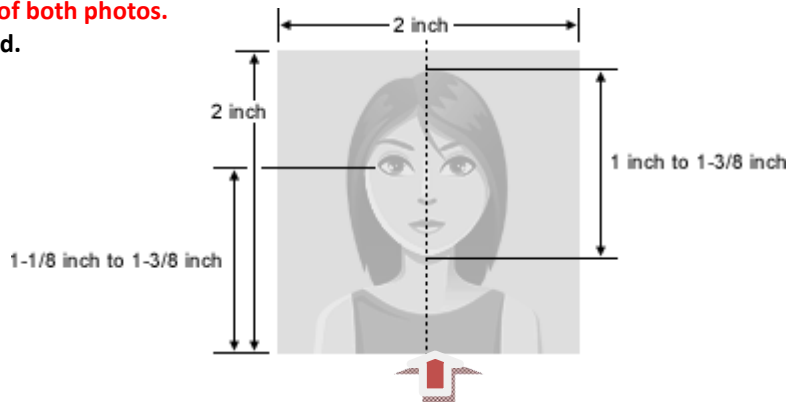
Documentation Required:

You MUST SEND a Copy of your CURRENT NBCOT Issued OTC® Certification Certificate or OTC® Photo ID Card. Failure to send a copy will result in your application being denied.

ID Photos Requirements: Both items 1 & 2 are required

- 1. A clear color photocopy of your valid driver's license or passport.**
- 2. 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 with tape from back

Do Not Staple or Tape Over Face

IMPORTANT POLICY REGARDING TESTING FOR THE OT-SC™

All OT-SC™ applicants should be aware of the following:

1. The OT-SC™ is not a standalone certification. It is not meant to replace the OTC® certification, only to enhance your original OTC® certification. **You must maintain the OTC® certification to keep your OT-SC™ certification.**
2. Upon successfully passing the OT-SC™ examination you will have your initial OT-SC™ certification period pro-rated to correspond to your OTC® expiration date.
For example: If your OTC® certification lapses in 2021 and you take and pass the OT-SC™ examination in 2019, your OT-SC™ credential will be valid from the date of passing the OT-SC™ examination until 12/31/2021 (the period when your OTC® lapses).

If you choose to recertify by CEU submissions, you will be required to submit with your OTC® CEU submissions, a prorated number of Category 1A credits by using the following table based on the length of your initial OT-SC™ certification:

1 Year:	3 CEUs
2 Years	6 CEUs
3 Years	9 CEUs
4 Years	12 CEUs
5 Years	15 CEUs
6 Years	20 CEUs

In the event that a certificant plans to retest for recertification of their OTC® credential, that certificant will be encouraged to wait to take the OT-SC™ examination until the year they are due to retest for their OTC® recertification, in doing so the OTC® and OT-SC™ expiration dates will coincide.

Following the initial OT-SC™ certification period, both the OTC® and OT-SC™ certifications would be valid for a period of six (6) years.

If you are recertifying your OTC® by examination, you must ALSO recertify your OT-SC™ by examination following successful testing of the OTC® examination during the same year.

I have read, understand, and agree to the above policy.

Print Name _____

Signature _____

Date Signed _____

**For Use with OT-SC™ Certification
OPERATING ROOM SUPERVISOR 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) with all information/documentation requested by NBCOT related to my OTC® Examination Application and certification eligibility.

Applicant Signature: _____

Date _____

Operating Room Supervisor: Please complete this section in its entirety.

I, _____, am the current Operating Room Supervisor for the Hospital/Surgery

Center at _____, located at _____
(Name of Facility) (Address)

- 1 I understand that the above-named individual is applying for Orthopaedic Technologist – Surgery Certified™ (OT-SC™) Certification, and that, as part of his/her OT-SC™ application, I am required to provide complete and accurate responses to the information identified in this Verification Form.

- 2 I attest and verify that to the best of my knowledge, the applicant named above has at least one (1) year of experience in Orthopaedic Surgery and has the necessary skills to be a competent Professional in the field of Orthopaedic Surgical Assisting. *(OR Supervisor's Signature attests to the Candidates expertise in the field of Orthopaedic Surgical Assisting).*

Signature of OR Supervisor

Date

Email Address

Telephone Number

NOTARY PUBLIC

State of _____

County of _____

On this _____ day of _____ in the year, before me, the undersigned notary public, personally appeared _____, 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

OT-SC 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) with all information/documentation requested by NBCOT related to my OTC® Examination Application and certification eligibility.

Applicant Signature: _____

Date _____

SUPERVISING PHYSICIAN ATTESTATION FORM

Supervising Physician: Please complete this section in its entirety

I, _____, am a physician licensed in the State of _____, specializing in the musculoskeletal system. I understand that the above-named individual is applying for the Orthopaedic Technologist -Surgery Certified (OT-SC™) Certification, and that, as part of his/her OT-SC™ application, I am required to provide complete and accurate responses to the information identified in this Verification Form.

I attest and verify that the applicant has the necessary skills and knowledge to fulfill the eligibility requirements to take the Orthopaedic Technologist – Surgery Certified (OT-SC) as outlined in the OT-SC™ Examination Breakdown and Standards of Practice.

The applicant has a minimum of twelve (12) months of experience in orthopaedic surgery.

I also certify that to the best of my knowledge, the information of the applying individual as reported in this application is accurate and complete.

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 OT-SC™ certification.

Signature of Supervising Physician

Date

Email Address

Telephone Number

I am currently employed with _____ (name of Group/Hospital),

located at _____ (address).

NOTARY PUBLIC

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
(NBCOT)**

CERTIFICATION ELIGIBILITY POLICY

The National Board for Certification of Orthopaedic Technologists, Inc. (NBCOT) requires that all NBCOT 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 in writing.

NBCOT 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 of ten (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 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 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 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 certification.

- 1. The seriousness of the disclosed matter.
- 2. The relationship of the disclosed matter to the applicant’s or certificant’s 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.
- 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 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 pursuant to this Policy.

Print Name: _____

Signature: _____

Date Signed _____

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 you **“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: _____

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.

- 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: _____

Please Print Name: _____

Signature: _____

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 Examination Handbook.

Please read this statement carefully.

I have read, understand, and agree to adhere to the provisions of the current National Board for Certification of Orthopaedic Technologists, Inc. Certification 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 NBCOT, 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 National Board for Certification of Orthopaedic Technologists, Inc. in writing of any violation of the Code of Ethics, specifically as it refers to Item 7.4 “Applicant Ethics Representations and Agreements”(e.g. felony charge and/or conviction, or suspension) which can be found within the 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 I was not eligible at the time I took the examination, my examination score will 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 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.

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, National Board for Certification of Orthopaedic Technologists, Inc. may verify my certification status. I hereby consent to National Board for Certification of Orthopaedic Technologists, Inc. release of any information regarding this application, my examination eligibility, my examination administration, or my certification status to any academic institution, employer, regulatory agency, or other party that may inquire in writing.

Please print name here: _____

Signature: _____

Date: _____

Examination Payment Section:

(If paying with a credit card, be sure to complete all sections below with signature)

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

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. Application will be returned unprocessed. \$40.00 will be charged for any returned funds by your bank.)

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

Visa® MasterCard®

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

OT-SC™ APPLICATION CHECK LIST

I have read the “Examination Candidate Handbook”, and I completely understand it.

I have signed all pages that require MY signature.

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 dismal papers) HAVE BEEN INCLUDED.

Privacy Statement is understood, and my “Option” is checked.

The “Physician and OR Supervisor Verification” statement is complete, with his/her signature present and NOTARIZED. There is NO EXCEPTION to this, even if you are recertifying by examination. The signature MUST BE a Licensed Physician only. (M.D., DO), **NOT a PA, OPA, OTC® or ANY other Allied Health Care Provider. There are NO exceptions to this.**

I have enclosed a copy of my current valid OTC® Certificate / ID Card.

I have enclosed a clear color photocopy of my photo ID. (Valid Driver’s License or Passport)

I have attached a clear color passport photo to page 4 and enclosed a second copy with the application.

I have enclosed the mandatory \$85.00 application fee. (Exception: Those who are currently certified and recertifying by exam).

I have enclosed the proper testing fees (NO PERSONAL CHECKS) made payable to the National Board for Certification of Orthopaedic Technologists (NBCOT). (If you know that you are filing LATE, you must include the late filing fee of \$100.00). Any submission received without the proper fees enclosed are returned unprocessed.

I have made a copy of all documents being submitted for my records.

I am mailing (Application cannot be emailed or faxed) FLAT this ORIGINAL “Examination Application” NOT a photocopy to:

**NBCOT Examinations
National Board for Certification of Orthopaedic Technologists, Inc.
4736 Onondaga Blvd. #166
Syracuse, NY 13219-3304**