



**ORTHOTIST/ PROSTHETIST
COMPETENCY VERIFICATION**

Name: _____

Please select: Orthotist Prosthetist

Please complete the following information, if applicable:

License #: _____ License expiration date: _____

Certification #: _____ Certification expiration date: _____

COMPETENCY CHECKLIST

Reviewer: Please indicate whether the above-named practitioner demonstrates competence in each skill by initialing under the "Yes," "No," or "N/A" column.

<u>Basic Skills:</u>	<u>Date:</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
Supply all orthotic needs of the patient as prescribed by the attending physician	_____	_____	_____	_____
Supply all prosthetic needs of the patient as prescribed by the attending physician	_____	_____	_____	_____

Additional comments: _____

Reviewer signature: _____

Reviewer name (printed): _____

Date: _____