

**Review Copy – Under No Circumstances Will the NCOPE Staff Accept This PDF Document.**

All submissions must be completing using the online application form:

<https://ncope.org/index.php/home-page-v2/residency-and-professional-experiences/residency-directors-mentors-and-administrator-information/residency-program-application/>



## Residency Program Application

*Attention: Text displayed in RED will not be shown in the actual application. It is only used for guidance when viewing this review copy.*

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By selecting the "Agree" option from the space below, you attest:

- 1) The information entered into this application is honest and accurate.
- 2) You have familiarized yourself with the current NCOPE Standards for Accreditation of Residency Programs and will adhere to them in the administration of the residency program if approved.
- 3) You have familiarized yourself with the current NCOPE Policy and Procedures Manual and will adhere to them in the administration of the residency program if approved.
- 4) You understand that a failure to provide required information will delay the application process and may result in the accrual of additional administrative fees from NCOPE.\*

- Agree
- Disagree
- 

### Basic Information: Application Type and Organization Information

*The application type chosen below will determine which questions are displayed.*

Identify the application type:\*

- 1st Time Application
- Renewal
- Additional Discipline or Dual Discipline Add-On Application

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- Affiliate Site - Add-On Application
- International Application
- Academic Institution Application

*Only sites undergoing a renewal or Add-On application will have a Residency Site-ID. It can be accessed by visiting the Residency Program Directory: <https://ncope.org/index.php/home-page-v2/residency-and-professional-experiences/residency-program-directory/>*

### Residency Site-ID

*This question is only shown to programs undergoing a renewal or add-on application.*

**Identify the disciplines or formats your residency program is currently approved to offer:\***

- Orthotics
- Prosthetics
- Dual-Discipline (Combined Orthotics & Prosthetics at least 18 months in duration)

*This question is only shown to programs undergoing a renewal or add-on application.*

**Would you like to add an additional discipline or dual-discipline format?**

*Please select "No" if you are already approved for orthotic, prosthetics and dual-discipline (combined O&P) residency formats.*

- Yes
- No

*This question is only shown to programs undergoing a renewal or add-on application.*

**Identify the disciplines or formats you wish to add to your current residency program:**

*Do not select any options that your residency program is already approved to offer*

- Orthotics
- Prosthetics
- Dual-Discipline (Combined Orthotics & Prosthetics)

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**Identify the disciplines or formats you wish to offer:**

- Orthotics
  - Prosthetics
  - Dual-Discipline (Combined Orthotics & Prosthetics)
- 

## **Organization Information**

*Please enter the primary physical location the facility seeking residency accreditation. You will have the opportunity to add additional facilities and/or affiliate locations on a subsequent page.*

Company Name\*:

Street Address\*:

Apt/Suite/Office:

City\*:

State\*:

Zip\*:

Country\*:

Phone Number\*:

Fax Number:

Company Website:

Website for Residency Candidates:

*The NCOPE Staff strongly encourages the residency program director to complete the application.*

**Identify the following information for the person completing this application.\***

First Name:

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Last Name:

Email Address:

Phone Number:

**Are you a residency program mentor and/or residency program director?\***

Yes

No

*This question is only shown for academic programs that integrate residency into their graduate degree program (example: The Baylor College of Medicine MSPO).*

**Identify the following information for the academic program director at the CAAHEP/NCOPE Accredited sponsor institution.\***

First Name:

Last Name:

Email Address:

Phone Number:

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## **Renewal / Add-On Information Verification**

*This question is only shown to programs undergoing a renewal or add-on application.*

**Is the individual you wish to have serve as the residency director listed as the current program director in the [NCOPE Residency Faculty Directory](#)?**

*No residency faculty members will not be listed if the residency program expiration date has already passed\**

Yes

No

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*This question is only shown to programs undergoing a renewal or add-on application.*

**Are any of the following components tied to the administration of the residency program changing from what was identified within the previous application?\***

	<b>Yes</b>	<b>No</b>
Mission statement	<input type="radio"/>	<input type="radio"/>
Residency tracks offered (Clinical / Research)	<input type="radio"/>	<input type="radio"/>
Resident selection procedures	<input type="radio"/>	<input type="radio"/>
Resident agreement documentation	<input type="radio"/>	<input type="radio"/>
Privileging policy	<input type="radio"/>	<input type="radio"/>
Orientation	<input type="radio"/>	<input type="radio"/>
Use of technology to enable direct supervision	<input type="radio"/>	<input type="radio"/>

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**Are any of the following resources or access to patient populations seen via the residency program at [question("value"), id="12"] changing from what was identified within the previous application?\***

	Yes	No
Frequency of orthotic encounters by device (FO, AFO, KAFO, TLSO, KO, Scoliosis, Upper Limb Orthoses)	<input type="radio"/>	<input type="radio"/>
Frequency of orthotic encounters by age group (Pediatric, Adult, Geriatric)	<input type="radio"/>	<input type="radio"/>
Frequency of prosthetic encounters by device (TT, TF, Partial Foot, UL, Post-Op)	<input type="radio"/>	<input type="radio"/>
Frequency of prosthetic encounters by age group (Pediatric, Adult, Geriatric)	<input type="radio"/>	<input type="radio"/>
Facility accreditation organization and/or type	<input type="radio"/>	<input type="radio"/>
Physical facilities, equipment or ancillary staff	<input type="radio"/>	<input type="radio"/>
The number of clinical locations	<input type="radio"/>	<input type="radio"/>

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residents will be rotating through		
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## **Standard I: Mission, Purpose, Objectives, Outcomes and Program Improvement**

**Enter the Mission Statement for the residency program in the space below:**

*Questions A-F listed below are only presented for residency programs undergoing a renewal application.*

**A) Enter the number of residents that have started AND finished their residency at the clinical site in the past three (3) years:**

**B) Enter the number of residents that have started AND DID NOT finish their residency at the clinical site in the past (3) years:**

**For each resident that started and did not finish their residency, provide a brief narrative as to the reason why this occurred.**

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**C) Enter the number of residents that pursued a dual-discipline (combined O&P) residency in the past three (3) years:**

*Do not include any residents that pursued consecutive single discipline (for example: 12 months orthotic followed by 12 months prosthetic) residencies in this number. Please enter 0 if the dual-discipline pathway was not offered.*

**D) Identify the relative percentage of orthotic exposures that were offered to the individuals that participated in a dual-discipline (combined orthotic & prosthetic) residents:**

*Only enter whole numbers for your response. There is no need to add any symbols or text.\**

**E) Identify the relative percentage of prosthetic exposures that were offered to the individuals that participated in a dual-discipline (combined orthotic & prosthetic) residents:**

*Only enter whole numbers for your response. There is no need to add any symbols or text.\**

**F) Did any resident enrolled in the dual-discipline pathway fall below 40% exposure in either prosthetic or orthotic clinical experiences?**

*If no residents pursued this pathway in the past 3 years, please select "No" from the options below.\**

Yes



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No

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## Standard II: Residency Requirements

**Identify the residency tracks that will be offered for the residency program:**

*Choose all that apply\**

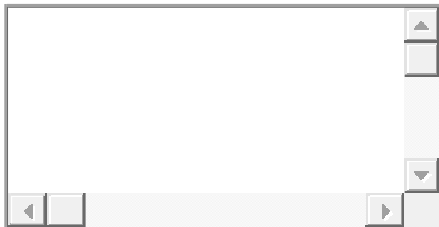
- Clinical
- Research & Development

**Does the residency program utilize technology such as steaming video, webcam or other means to enable direct supervision of residents?**

*This is common only with residency programs where the residents engage in patient care in a location physically separate from the primary location.*

- Yes
- No

**Provide a summary of how technology is leveraged to enable direct supervision in the space provided below:**



**Does the residency program offer a non-traditional format (mobile office), which requires the residents to drive/commute to provide services in non-accredited facilities?**

*This includes locations operated by the residency site in addition to any affiliate locations.\**

- Yes
- No

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**Enter the maximum number of concurrent residents that you would host at a given period of time?**

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## **Residency Requirements (Continued) - Orthotics**

**For each orthosis listed below, identify the number of patient encounters you anticipate the resident practitioner will have exposure to over the course of the residency program:\***

	<b>Enter a Whole Number</b>
Foot orthosis	<input type="text"/>
Ankle-foot orthosis	<input type="text"/>
Knee orthosis	<input type="text"/>
Knee-ankle-foot orthosis	<input type="text"/>
Scoliosis orthosis	<input type="text"/>
Hip orthosis	<input type="text"/>
Cervical orthosis	<input type="text"/>
Thoraco-lumbo-	<input type="text"/>

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sacral orthosis	
Lumbo-sacral orthosis	<input type="text"/>
Wrist-hand orthosis	<input type="text"/>

**For each patient age group, identify the relative percentage of time you anticipate the resident will spend with this population providing orthotic care:**

*The values should total to 100%\**

Pediatric (0-17 y/o)

Adult (18-64 y/o)

Geriatric (65+ y/o)

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## **Residency Requirements (Continued) - Prosthetics**

**For each prosthesis listed below, identify the number of patient encounters you anticipate the resident practitioner will have exposure to over the course of the residency program:**

	<b>Enter a Whole Number</b>
Transtibial prosthesis	<input type="text"/>
Transfemoral prosthesis	<input type="text"/>

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Upper limb prosthesis	<input type="text"/>
Symes and/or partial feet prosthesis	<input type="text"/>
Post operative care	<input type="text"/>

**For each patient age group, identify the relative percentage of time you anticipate the resident will spend with this population providing prosthetic care:**

*The values should total to 100%\**

Pediatric (0-17 y/o)

Adult (18-64 y/o)

Geriatric (65+ y/o)

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## **Residency Requirements (Continued) - Combined Orthotics & Prosthetics**

*Questions A & B listed below will only be displayed for programs seeking to offer a dual-discipline residency program.*

**A. Identify the anticipated relative percentage of orthotic exposures that will be offered to dual-discipline (combined orthotic & prosthetic) residents:**

*Only enter whole numbers for your response. There is no need to add any symbols or text.*

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**B. Identify the anticipated relative percentage of prosthetic exposures that will be offered to dual-discipline (combined orthotic & prosthetic) residents:**

*Only enter whole numbers for your response. There is no need to add any symbols or text.\**

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## **Standard III: Administration and Resources of the Residency Program**

**Select the O&P Facility Accreditation(s) held:**

*Choose all that apply*

*\* You do not need to report any local or state business licenses\**

- American Board for Certification (ABC)
- Board of Certification in Orthotics & Prosthetics (BOC)
- State Facility Licensure
- Other - Write In (Required): \*

**Which setting best describes where the primary clinical education of residents will take place?\***

- Private Practice (Outpatient Facility not within a Hospital or University)
- College / University
- Hospital / Interdisciplinary Care Clinic
- Federally Funded Military Care Facility (VA / DOD)
- Other - Write In (Required)

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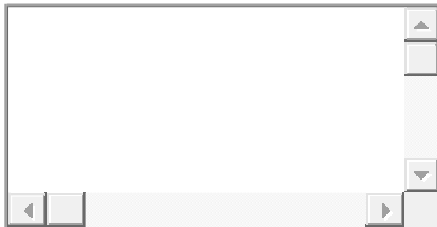
**Which settings will the residents have the opportunity to rotate through?**

*Choose all that apply\**

- Private Practice (Outpatient Facility not within a Hospital or University)
- College / University
- Hospital / Interdisciplinary Care Clinic
- Federally Funded Military Care Facility (VA / DOD)
- Other - Write In (Required): \*

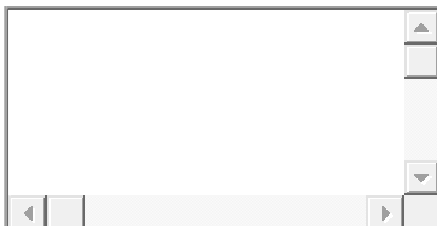
*For many organizations, this will be the same as the hiring procedures defined in the company's policy & procedure manual.*

**Provide a summary of the written selection procedures in the space provided below:**



**Provide a summary the Resident Agreement including:**

- **Program duration (if different program lengths are offered, please explain all options)**
- **Weekly hours (including the total number of hours, start/end times and if there are any expectations to perform tasks outside of normal business hours including on-call)**
- **Compensation**
- **Benefits**
- **Liability coverage**
- **Requirements for successful completion of the residency**



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**Are resident practitioners required to sign a non-compete agreement?\***

- Yes
- No

*For many organizations, this will be the same as the hiring procedures defined in the company's policy & procedure manual.*

**Provide a summary the orientation to the residency program:**



**Enter the number of physical locations owned/operated by the primary residency site that residents will rotating through in addition the primary location previously identified:**

*Please do not include any affiliation sites. If you are establishing an affiliation agreement with an outside O&P facility, you will be prompted later to identify the number of affiliation sites in a later question. \**

**Provide a description of facilities, equipment and ancillary staff available to enable the mission, goals, and objectives of the O&P residency program including the primary location and any additional locations identified in the previous question.**

**- Include confirmation that residents will have daily and/or weekly access to a computer with internet access or the ability for the resident to bring personal laptop into the office and be provided internet access**

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**Do the patient populations, residency program mentors, equipment, facilities and support staff at [question('value'), id='12'] to provide a full scope of experience for the resident to attain their required competencies and experiences? \***

- Yes
- No

**Does the residency program have or plan to have an affiliation agreement in place with a separate O&P provider as part of the residency program? \***

- Yes
- No

**Enter the number of affiliate sites you wish to add:\***

**Enter the number of clinical sites more than 75 miles away from the primary residency site that residents have the opportunity to rotate through. \***

*This question is only shown if a residency program plans to have an affiliation agreement*

**Enter the names of the clinical facilities that will participate in the affiliation agreement:**

*In addition to the narrative provided, you will be prompted in a subsequent question to upload copies of the agreement documentation. You will be prompted about the exposures enabled by each affiliate location later in this application.\**



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## International Residency Program Information

**A) Is [question("value"), id="12"] credentialed or approved by an agency or governing body to offer prosthetic and/or orthotic services? \***

Yes

No

**B) Enter the name of the agency that has approved the organization to offer orthotic and/or prosthetic services\***

**C) What recognition has been granted by the agency listed above to allow the organization to offer orthotic and/or prosthetic services?\***

**D) When does the recognition identified above expire?\***

**E) Enter the website for the agency identified in the question above that has approved the organization to offer orthotic and/or prosthetic services\***

**F) Will the residents interact with persons who do not hold ABC practitioner certification or ISPO Category I (Orthotist/Prosthetist) within the organization? \***

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**G) Identify the title/role and credentials held by persons without the ABC/ISPO credentials listed above who will interact with the residents. Provide a brief description of their role within the [question("value"), id="12"]. \***



**H) Upload images of the patient care areas, manufacturing spaces, and practitioner administrative areas. Provide a description of the spaces being shown using the comment box. You may upload up to 10 images using JPG format.**

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## Faculty Roles & Responsibilities

### Residency Director:

First Name\*:

Last Name\*:

Work Email Address\*:

Work Phone Number\*:

**Identify the certification/credential held by the clinician identified above:\***

- ABC Certified Orthotist
- ABC Certified Prosthetist
- ABC Certified Prosthetist / Orthotist
- BOC Orthotist
- BOC Prosthetist
- BOC Prosthetist / Orthotist
- Licensed Orthotist

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Licensed Prosthetist

Other - Write In (Required): \*

**Identify the sections of the [Residency Program Development Course](#) that the individual listed above has completed:**

*Select all that apply*

S1: Preparation to be a Residency Program

S2: Development of a Residency Program

S3: Assessment in the Residency Program

**Alternatively, the individual above may have pursued the [Approved Clinical Mentor \(ACM\)](#) credential instead. Has the individual completed the ACM course?\***

Yes

No

**How many clinical mentors will be supervising resident practitioners for the residency program?**

*Do not include the residency director in the total number entered below. If the residency director will be the sole mentor, please enter "0" in the space below.\**

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## Faculty Roles & Responsibilities (Continued)

*The following fields will be repeated once for each mentor identified in the prompt above.*

### Residency Mentor 1:

First Name\*:

Last Name\*:

Work Email Address\*:

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Work Phone Number\*:

*The following fields will be repeated once for each mentor identified in the prompt above.*

**Identify the certification(s)/credential(s) held by the clinician identified above:**

*Choose all that apply\**

- ABC Certified Orthotist
- ABC Certified Prosthetist
- ABC Certified Prosthetist / Orthotist
- BOC Orthotist
- BOC Prosthetist
- BOC Prosthetist / Orthotist
- Licensed Orthotist
- Licensed Prosthetist
- Other - Write In (Required): \*

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## **Director/Mentor Proof of NCOPE Training**

*Copies of the certificates completed via the Academy's Online Learning Center (anyone who took the course prior to 2018) can be requested directly via their portal. Certificates of completion for individuals who completed the course using the Canvas LMS (first offered in 2018) can download copies by visiting:*

<https://www.credential.net/retrieve-credentials>

**Upload PDF copies of the director and each mentor's certificates for the online development courses OR ACM.**

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## **Residency Director Details**

**Please enter the following information for individual listed above:**

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**Select the O&P School that the individual graduated from:**

- Alabama State University
- California State University - Dominguez Hills
- Loma Linda University
- University of Hartford
- University of Connecticut / Newington
- Florida International University
- Georgia Institute of Technology
- Northwestern University
- University of California - Los Angeles
- New York University
- Eastern Michigan University
- Century College / Concordia University - St. Paul
- University of Pittsburgh
- Baylor College of Medicine
- University of Washington
- University of Texas - Southwestern Medical Center
- Other US Institution Not Listed
- Other Foreign Institution Not Listed

**What level degree was awarded upon graduation from the school above?\***

- Associates
- Bachelors
- Certificate
- Masters

In what year did the individual graduate from O&P School?\*:

In what year(s) did the individual attain their certification/license credential(s)?:

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Enter the certification and/or license number(s) held by the individual for those credentials:

*For certifications, enter the letters preceding any numbers. For each license, enter the two (2) letter state abbreviation where the license was granted. Separate multiple responses using a comma (,).\*:*

**Is the individual currently in good standing with the organizations that awarded the following credentials?**

- Yes
- No

**Has the individual ever been disciplined by an O&P credentialing body and/or had their license/certification suspended or revoked?**

- Yes
- No

**Upload a copy of the residency director's O&P school transcripts:**

*The following question will only be displayed if the director obtained their O&P schooling outside of the US.*

**Upload a WES Education verification for the institution listed above in PDF format:**

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## **Criminal History Attestation**

**Has any owner or facility personnel involved in the residency program ever been convicted of, or plead guilty to or nolo contendere (no contest) to a felony or a crime involving a patient? \***

- Yes
- No

**Has any owner or facility personnel involved in the residency program ever been charged with a felony and plead guilty to, or been convicted of a lesser charge (e.g. misdemeanor)? \***

- Yes

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No

**Has any owner or facility personnel involved in the residency program ever been charged with a felony which has yet to be dismissed?\***

Yes

No

**Has any owner or facility personnel ever been prohibited from doing business with any division of the federal government or is on the Office of Inspector General's (OIG) Execution List? \***

Yes

No

**Provide a detail narrative for each statement above where the response was "Yes" including the following information:**

- 1) The name of the individual**
- 2) A description of the events that resulted in the citation**
- 3) The date(s) that the citation occurred**

**Upload a detailed narrative for each statement above where the response was "Yes" including the following information:**

- 1) The name of the individual**
- 2) A description of the events that resulted in the citation**
- 3) The date(s) that the citation occurred**

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**Provide the following information about additional residency location 1**

*Questions A – B will be repeated once for each additional location within the organization.*

**A) Location Information**

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Street Address\*:

Apt/Suite/Office:

City\*:

State\*:

Zip\*:

Country\*:

Phone Number\*:

Fax Number:

**B) Provide the following information for the primary mentor at this location:**

Primary Mentor Name:

Primary Mentor E-Mail:

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## **Provide the following information about affiliate location 1**

*Questions A – B will be repeated once for each additional location within the organization.*

**A) Enter the name of the organization that operates this affiliate location:\***

**B) Location [page("piped value")] Information**

Street Address\*:

Apt/Suite/Office:



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City\*:

State\*:

Zip\*:

Country\*:

Phone Number\*:

Fax Number:

**C) Identify the patient populations that the resident will be exposed to at this location:**

*Choose all that apply\**

- Pediatrics (0-17 y/o)
- Adult (18-64 y/o)
- Geriatric (65+ y/o)

**D) Identify the required orthotic exposures that will occur at this affiliate site:**

*Choose all that apply. If no prosthetic exposures will be offered at this site, you may leave all options blank.*

- FO
- AFO
- KAFO
- KO
- Scoliosis
- Upper Limb Orthoses
- Hip Orthoses
- LSO
- TLSO
- Cervical Collars

**Review Copy** – Under No Circumstances Will the NCOPE Staff Accept This PDF Document.

All submissions must be completing using the online application form:

<https://ncope.org/index.php/home-page-v2/residency-and-professional-experiences/residency-directors-mentors-and-administrator-information/residency-program-application/>

**E) Identify the required prosthetic exposures that will occur at this affiliate site:**

*Choose all that apply. If no prosthetic exposures will be offered at this site, you may leave all options blank.*

- Partial Foot / Symes
- Transtibial
- Transfemoral
- Upper Limb
- Post-Operative

**F) Provide the following information for the primary mentor at this location:**

Primary Mentor Name::

Primary Mentor E-Mail::

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## Payment Type and Residency Agreement

How would you like to submit payment?\*

- Credit Card
- Check/Money Order
- Other - Write In (Required): \*

## Residency Agreement

**The undersigned Organization makes application to The National Commission on Orthotic and Prosthetic Education (NCOPE) for voluntary accreditation of the Organization and certifies that the information recorded in this application and attachments is true and correct. The Organization agrees, at all times, as a condition for residency program accreditation, to provide information requested by NCOPE relevant to the review, evaluation and maintenance of the Organization's residency program accreditation status.**

**Information obtained or generated by NCOPE in the accreditation process is solely for the purpose of reviewing the professional service of, and the quality of care provided or arranged by, the Organization, NCOPE acknowledges that the information obtained or**

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**generated by NCOPE shall be considered confidential between the Organization and NCOPE and shall be treated on a confidential basis, except as otherwise provided in NCOPE's policies or a required by law, a court of law or a governmental agency. NCOPE will not take possession of any private health information about which it becomes aware during the course of NCOPE's investigation of this application.**

**The Organization understands that all fees associated with this application are non-refundable and agrees that it is solely responsible for being aware of and understanding NCOPE accreditation standards and that failure to do so will result in loss of NCOPE accreditation status. The Organization is responsible for immediately being in compliance with existing, new and/or modified accreditation standards, as and when they are adopted by NCOPE. The Organization must notify NCOPE in writing of any changes to this application.**

**The Organization agrees to abide by and be bound by the NCOPE Standards of Accreditation for The Orthotic/Prosthetic Residency Program, NCOPE Policies & Procedures, and the ABC Code of Professional Responsibility & Rules and Procedures including any revisions that occur while applying or serving as a residency program.**

**The Organization's failure to abide by these terms and conditions may result in sanctions, including loss of accreditation status, against the organization.**

**By selecting "Agree" in the box below, you are indicating that you agree to the terms of the residency agreement.\***

Agree

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**Would you like to download a copy of the completed application in PDF format? \***

Yes

No

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