



Information Request: MAPS Fellowship Program in Orthopedic Manual Therapy

Through December 31, 2018, eligible applicants **MUST** have a **valid PT license**, at least 2 years clinical outpatient experience (with at least 1 year in orthopedics) **AND** meet **at least one** of the following criteria:

- An Orthopedic Certified Specialist (OCS) designation
- Be a graduate of an APTA credentialed Orthopedic Residency Program
- Or the equivalent of either of the above through professional portfolio review

Note: ABPTRFE rule changes scheduled to become effective January 1, 2019 requires fellowship candidates to have either their OCS or a certificate of completion from an accredited orthopedic residency program.

PERSONAL CONTACT INFORMATION

Name: _____ E-mail: _____
 Phone: _____ Alternate phone: _____
 Mailing address: _____

PROFESSIONAL INFORMATION

Educational designations (e.g., PT, DPT, PhD, DO, etc.): _____
 Additional professional certifications (e.g. COMT): _____
 Number of years practicing PT: _____ States in which you are a licensed PT: _____
 MAPS courses successfully completed (to date): _____

CURRENT EMPLOYMENT:

Name of Company/Clinic: _____
 Address of Company/Clinic: _____

 Phone: _____ Fax: _____ E-mail: _____

EMPLOYMENT AND EDUCATION HISTORY

Please include a copy of your most recent resume/CV, including any continuing education courses you have taken in the last five years.

INFORMATION DISCLOSURE AGREEMENT:

I attest that the information provided on this form is truthful. I also understand that any information provided to me from MAPS and/or the MAPS Fellowship Program is confidential protected information, which may not be disseminated to any third party without advance written permission and/or approval of MAPS. I further agree not to share the information received from the MAPS Fellowship Program and/or its curriculum with any third parties, with the exception of my personal financial or legal counsel and my immediate family members. The information received may be shared with my employer **only** for the purpose of obtaining approval or consent to apply to the Program or to be reimbursed for participation in the Program.

X _____ Date: _____
Your Signature