Information Request: MAPS Fellowship Program in Orthopedic Manual Therapy

Through December 31, 2017, 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*

Note: ABPTRFE rule changes scheduled to become effective January 1, 2018 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:____

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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: ____

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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

Email form to Meghan@ozpt.com, fax to 631-298-3810/5872 or mail to MAPS, PO Box 1244, Cutchogue, NY 11935

www.ozpt.com Tel: 1-800-828-0738