



Texas Department of Licensing and Regulation

PO Box 12057 • Austin, Texas 78711-2157

(800) 803-9202 • (512) 463-6599 • FAX (512) 475-2871

www.tdlr.texas.gov • cs.op@tdlr.texas.gov

ATTESTATION OF EXPERIENCE PROVIDING EXTENSIVE PROSTHETIST CARE INSTRUCTIONS

All information provided must be typed or printed in **black ink**. **ONLY** those applying for a regular license under **Unique Qualification** must submit this form.

1. **APPLICANT NAME** – Write your legal name in the spaces provided. (Last, First, Middle Name, Suffix) Examples of a suffix include Jr., Sr., and II. (Mr. is not a suffix.)
2. **SOCIAL SECURITY NUMBER** – Social Security number disclosure is required by Section 231.302(1) of the Texas Family Code in order to obtain a license. Your social security number is subject to disclosure to an agency authorized to assist in the collection of child support payments. For more information regarding child support payments, contact the Texas Attorney General at:

www.oag.state.tx.us/child/index or call (512) 460-6000 or (800) 252-8014
3. **PHONE NUMBER** – Write a telephone number, including the area code, where we can reach you during the day. This may be your office phone number where we can leave a message.
4. **EMAIL ADDRESS** – Write your email address. Please provide your email address so the department may email license information and required notices to you. Your email address is confidential pursuant to the Texas Public Information Act, and the department will not share it with the public.
5. **EXTENSIVE PROSTHETIST CARE** – Include **all of** the following experiential elements:
 - Evaluation of patients with a wide range of upper and lower limb deficiencies;
 - Taking measurements and impressions of the involved body segments, the synthesis of observations and measurements onto a custom Prosthetist design;
 - Selection of materials and components;
 - Fabrication of functional prostheses including plastic forming, metal contouring, upholstering, assembly, and aligning;
 - Fitting and critique of the prosthesis;
 - Appropriate follow-up, adjustments, modifications and revisions in a Prosthetist facility;
 - Instructing patients in the use and care of the prosthesis; and
 - Maintaining current encounter notes and patient records.
6. **DATES PERFORMED EXTENSIVE PROSTHETIST CARE** – Enter the beginning and ending dates.
7. **SIGNATURE AND DATE** – Sign and Date the form.



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**ATTESTATION OF EXPERIENCE PROVIDING
 EXTENSIVE PROSTHETIST CARE**

DO NOT WRITE ABOVE THIS LINE

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1. Applicant Name: _____
 Last First Middle Name Suffix

2. Social Security Number: _____ 3. Personal Phone Number: _____ 4. Email Address: _____
 ()

(See Instructions Sheet for Disclosure Information) Area Code Phone Number (Ex: johndoe@aol.com) See Instructions sheet for Disclosure

5. Extensive Prosthetist Care must include all of the following experiential elements:
- Evaluation of patients with a wide range of upper and lower limb deficiencies;
 - Taking measurements and impressions of the involved body segments, the synthesis of observations and measurements onto a custom Prosthetist design;
 - Selection of materials and components;
 - Fabrication of functional prostheses including plastic forming, metal contouring, upholstery, assembly, and aligning;
 - Fitting and critique of the prosthesis;
 - Appropriate follow-up, adjustments, modifications and revisions in a Prosthetist facility;
 - Instructing patients in the use and care of the prosthesis; and
 - Maintaining current encounter notes and patient records.

(I attest that I have applied all the above listed experiential elements to two-thirds of the orthoses listed in the chart below. (6 of 9 items must be completed in order to qualify).

Prosthesis	Completion Location	Completion Date (First and Last Date Performed)	Name & Phone No. of Verification Source (Not patient's names)
<i>Example Prosthesis</i>	<i>XYZ O&P, Austin TX</i>	<i>10/97 – 10/13</i>	<i>Pete Jones at XYZ, (512) 455-5555</i>
wrist disarticulation			
below elbow			
above elbow			
shoulder disarticulation			
partial foot			
Symes			
below knee			
above knee			
hip disarticulation			

6. I have performed extensive Prosthetist care from _____ / _____ to _____ / _____

7. The above information is true and correct. I understand that providing false or misleading information in, with, or concerning my license application may be cause for denial or loss of licensure. I understand that knowingly providing false information on a government document is punishable by a state jail felony. This form does not constitute application for licensure.

Signature of Applicant _____ Date _____