



TEXAS DEPARTMENT OF LICENSING & REGULATION

P.O. Box 12157 • Austin, Texas 78711-2157

www.tdlr.texas.gov

ORTHOTISTS AND PROSTHETISTS VERIFICATION OF EXPERIENCE INSTRUCTIONS

1. APPLICANT NAME – Provide 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. APPLICANT MAILING ADDRESS – Provide your current mailing address. This is the address where we will send you mail. This address can be a post office box. Add the zip plus-4 to help the postal service deliver mail more efficiently and accurately.
3. APPLICANT PHONE NUMBER – Provide 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. APPLICANT EMAIL ADDRESS – Provide 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. EMPLOYER NAME – Provide 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.)
6. EMPLOYER JOB TITLE – Provide the job title of the person who employs you, listed in Item 5.
7. EMPLOYER PHONE NUMBER – Provide 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.
8. EMPLOYER EMAIL ADDRESS – Provide 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.
9. EMPLOYER MAILING ADDRESS – Provide your current mailing address. This is the address where we will send you mail. This address can be a post office box. Add the zip plus-4 to help the postal service deliver mail more efficiently and accurately.
10. CHOOSE THE TYPE OF WORK PERFORMED – Place a check in the box of the work performed by the applicant.
11. GIVE A BRIEF DESCRIPTION OF THE JOB DUTIES THE APPLICANT HAS PERFORMED
12. TOTAL NUMBER OF HOURS WORKED AT THE DUTIES LISTED IN ITEM 11
13. DATES EMPLOYED – Give the dates the applicant was trained by you.
14. STATEMENT OF EMPLOYER – Carefully read the statement before signing and dating the form.

SEND YOUR COMPLETED APPLICATION AND REQUIRED DOCUMENTS TO:

TDLR
P.O. Box 12157
Austin, TX 78711-2157

Documents submitted with your application will not be returned. Keep a copy of your completed application, all attachments, and your check or money order. Do not send cash.

For additional information and questions, please visit the [TDLR website](http://www.tdlr.texas.gov). You can request assistance or submit required attachments via [TDLR webform](#) or fax (512) 475-2871. You may contact Customer Service Representatives by calling (800) 803-9202 (in state only) or (512) 463-6599; Relay Texas -TDD (800) 735-2989. Customer Service Representatives are available Monday through Friday (excluding holidays).

TDLR Public Information Act Policy:

This document is subject to the Texas Public Information Act. With certain exceptions, information in this document may be made available to the public. For more information, view the [TDLR Public Information Act Policy](#).



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ORTHOTISTS AND PROSTHETISTS VERIFICATION OF EXPERIENCE

BE SURE TO USE A SEPARATE FORM FOR EACH ORGANIZATION OR INSTITUTION WHERE THE EXPERIENCE WAS GAINED. BE SURE TO SUBMIT EXPERIENCE SUFFICIENT TO DOCUMENT YOUR EXPERIENCE FOR THE DURATION REQUIRED OF YOUR LICENSE. THIS FORM MUST BE COMPLETED BY A PERSON QUALIFIED TO VERIFY EXPERIENCE WHOM THE DEPARTMENT MAY CONTACT FOR VERIFICATION.

1. Applicant Name:

Last

First

Middle Name

Suffix

2. Applicant Mailing Address:

P.O. Box, Number, Street Name, Apt Number

City

State

Zip Code

3. Applicant Phone Number:

(Area Code) Phone Number

4. Applicant Email Address:

See instruction sheet for disclosure information

5. Employer Name:

Last

First

Middle Name

Suffix

6. Employer Job Title:

7. Employer Phone Number:

(Area Code) Phone Number

8. Employer Email Address:

See instruction sheet for disclosure information

9. Employer Mailing Address:

P.O. Box, Number, Street Name, Apt Number

City

State

Zip Code

10. Choose the type of work performed by this applicant: (Please place a check in the box)

Orthotist

Prosthetist

Orthotist/Prosthetist

11. Briefly describe job responsibilities:

12. Total number of hours per week the applicant worked in the above duties:

13. Dates Employed:

From:

to:

14. STATEMENT OF EMPLOYER

I certify that I have employed the above applicant and that I know of my own knowledge that said person was employed as follows and that his/her regularly assigned duties including work in the Orthotist and/or Prosthetist field. I understand that I may be subject to disciplinary action up to and including revocation of my license if I verify experience other than that which was performed while the applicant was working under my license and supervision.

Signature of Employer

Date