asop THE AMERICAN SOCIETY OF ORTHOPEDIC PROFESSIONALS

Registered Orthopedic Technologist (ROT) Exam Application

Read and sign all of the information requested below.
Once completed, please email form to ASOP Support Team - asop.jacob@gmail.com

Last Name: ______________________________________ First Name: ______________________________________

Home Mailing Address:____

City/State/Province/Zip:____E-Mail Address: __________________________________

Cell Phone :(_____) __________________

Work Phone :(_____) __________________ Fax Number: (_____)__________________

Highest Academic Level: High School 1 to 3 yrs college Bachelors Masters

Primary Place of Employment: Hospital Private Practice Military Other: _______________

Orthopedic Experience: 1 Year 2 Years 3-5 Years 6-10 Years +10 Years

Other Professional Certifications/Licenses? ____

Physician Verification: Physicians who specialize in orthopedics and urgent care can attest to the expertise of the applicant **MUST** complete this section. I certify that, to the best of my knowledge, the experience of the above individual as reported in this application is correct and complete. I further certify that the applicant has the necessary experience, skills and knowledge in applied orthopedic cast technology for ROT examination eligibility.

____ ____
Name of Attesting Orthopedic Physician (Print) Signature of Attesting Orthopedic Physician

____
Work Address:

____
City/State/Zip

I, ____________________________, attest to the fact that I have fulfilled the eligibility requirements for the ASOP Registered Orthopedic Technologist examination as stated, including necessary educational and/or work experience.

Applicant Signature____ Date:______________________

___ ***No-fee for ASOP Members*** ___***$200.00 NON Members***

I HEARBY AUTHORIZE ASOP to charge the above amount to my credit card. You will receive a 2 year ASOP Membership

❑ Visa ❑ MasterCard

Card Number: ____ Exp. Date: ___________ CID #: ________ (3 digits)

Print Name Exactly as it appears on card: ____

Cardholder Signature: ____ Cardholder Phone :(_____) __________________

Cardholder Billing Address: ____

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City/State/Zip