asop THE AMERICAN SOCIETY OF ORTHOPEDIC PROFESSIONALS

# Total Contact Cast (TCC-C) Exam Application

**Read and sign all of the information requested below.**
**Once completed, please upload into supervisor verification portal**

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 _____

Physician Verification: Physicians who specialize in orthopedics, podiatry, sports medicine 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 total contact casting application for TCC-C examination eligibility.

_____ _____
Name of Attesting Physician (Print) Signature of Attesting Physician

_____
Work Address:

_____
City/State/Zip

I have read the eligibility requirements and understand that I am responsible for knowing its contents. I certify that the information given in the initial application and this verification form is accurate, correct and complete.

I authorize the ASOP to verify my credentials and professional standing in order for me to qualify to sit for the TCC certification exam. Further, I understand that ASOP will treat the contents of this application as well as all documents relating to certification as confidential, except as necessary to administer the certification program. Lastly, I fully recognize that this certification does not supersede existing laws and other regulatory requirements that I am required to abide by relevant statutes and regulations. I understand that after earning the credential, I am responsible for complying with all obligations for maintaining the credential, including any continuing education requirements within the specified time period and for making application for renewal of my certification. I have read and understand the information related in the eligibility requirements and will abide by the same.

I further authorize ASOP to release my current certification status at any time post-certification upon request, written or verbal. I acknowledge that it is the policy of the ASOP not to release information regarding the scores obtained on the exams or to release information regarding the number of times a candidate has sat for the exams.

**CANDIDATE VERIFICATION:**

Candidate Printed Name:_____ Date:_____