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