2024-2025
ASOP Registered Orthopedic Technologist Surgical Certified (ROT-SC)

Supervisor / Orthopedic Physician Verification Form

ORTHOPEDIC SUPERVISOR INFORMATION:

By affixing my signature below, I attest to and verify that the below-named applicant for this certification examination to the best of my knowledge, meets the eligibility requirements with a minimum of six (6) months experience in orthopedic surgery.

Supervisor/Ortho Physician Name:_____Title:_____

Signature:_____Date:_____

Organization:_____ Phone: _____

CANDIDATE INFORMATION:

Applicant Name:_____
First MI Last

Email:_____ Phone:_____

ROT Certification ID # (if known)_____

CANDIDATE SIGNATURE:

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 ASOP to verify my credentials and professional standing in order for me to qualify to sit for the ROT-SC 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 recognize that this certification does not supersede existing laws and other regulatory requirements and 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 further understand that it is my responsibility to inform ASOP of any changes in my email or mailing address. I have read and understand the information provided in the eligibility requirements and will abide by the same. I declare that all information provided on my application is true. I understand that false information may be cause for denial or loss of credential. I understand that I can be disqualified from taking or continuing to sit for an examination or from receiving examination scores, or I may have my examination scores disqualified, if ASOP in its sole judgment, determines through either proctor observation or statistical analysis that I engaged in collaborative, disruptive, or other inappropriate behavior related to administration of the examination.

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 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 SIGNATURE:

Candidate's Printed Name:_____ Date:_____