



National Board For Certification of Orthopaedic Technologists
Certified Letter Verification of Certification Request Form

To request a Certified Stamped Letter verifying an OTC® or OT-SC™ Certification, complete this form and enclose a signed release of information by the credential holder. Please Print Clearly or Type your request. The letter will include: Credential holder's name, Certification Number, day-month-year certified, day-month-year of recertification (renewal date), with current status as an OTC® or an OT-SC™. Report will include any disciplinary comments or actions, pending or taken. This letter is only processed if a credential holder is currently certified. We do not verify or report on lapsed certification requests. We do not report exam scores. You will receive the Certified Stamped Letter(s) of verification by standard US Mail within 10 days of our receipt of this form to your address provided below. All information provided by you below is secured and must be provided to have your request processed. We require full Social Security numbers to be provided. If ALL information is not provided, this form will be returned unprocessed to you. Questions regarding this verification request should be directed to the NBCOT by calling our office toll free, (866) 466-2268.

Date of your Request: Certificate Number(s) provided to you:

Circle Credential you are verifying: OTC® OT-SC™ Both (provide both numbers above)

Were you provided with a copy of the Certification Certificate(s) that you are verifying? Yes No

Current full name of credential holder:

Current Home Address of credential holder:

City, State, Zip:

Current Home Phone of credential holder: Daytime Phone:

Credential holders Social Security Number: - -

I am verifying for a State Board; Employer; or Credentialing Agency authorized to request this information.

Name: Attn:

Address:

City, State, Zip: Phone: () - Ext.

Method of Payment (\$30.00 per letter) O Visa O MasterCard (We do not accept AMEX/Discover)

PRINT Name EXACTLY on Credit Card:

Credit Card Number: - -

Expiration Date: Month Year CID # (last 3 digits on back of Card)

I am the card holder or I am authorized to approve the full charge below to be placed on the card listed above:

Number of Letters requested: Amount of Credit Card Charge: \$

Cardholder Signature:

(Required for ALL Credit Card Requests)

Credit Card Billing Statement Address:

(Address where Credit Card Bill is received)

City, State, Zip:

Telephone Number Associated with Credit Card: () - Ext:

Circle one: Official Bank Check Group Employer Check Money Order

Mail completed form, including a signed Release of Information form attached to:

NBCOT Letter Verifications
4736 Onondaga Blvd. #166
Syracuse, NY 13219