



## Information Request: MAPS Fellowship Program in Orthopedic Manual Therapy

**IMPORTANT NOTE:** Applicants **MUST** have a **valid PT license & AT LEAST one of the following:**

- An Orthopedic Certified Specialist (OCS) designation
- Be a Graduate of an APTA Credentialed Orthopedic Residency Program
- 2,000 **clinical** hours managing orthopedic conditions

### **PERSONAL CONTACT INFORMATION**

Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

### **PROFESSIONAL INFORMATION**

Educational designations (e.g., PT, DPT, PhD, DO, etc.): \_\_\_\_\_

Additional Professional Certifications (e.g. COMT): \_\_\_\_\_

Number of Years practicing PT: \_\_\_\_\_ States in which you are a licensed PT: \_\_\_\_\_

MAPS Courses successfully Completed: \_\_\_\_\_

### **CURRENT EMPLOYMENT:**

Name of Company/Clinic: \_\_\_\_\_

Address of Company/Clinic: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

### **EMPLOYMENT AND EDUCATION HISTORY**

Please include a copy of your most recent resume/CV, including any Continuing Education Courses you have taken in the last five years.

### **INFORMATION DISCLOSURE AGREEMENT:**

I attest that the information provided on this form is truthful. I also understand that any information provided to me from MAPS and/or the MAPS Fellowship Program is confidential protected information, which may not be disseminated to any third party without advance written permission and/or approval of MAPS. I further agree not to share the information received from the MAPS Fellowship Program and/or its curriculum with any third parties, with the exception of my personal financial or legal counsel and my immediate family members. The information received may be shared with my employer **only** for the purpose of obtaining approval or consent to apply to the Program or to be reimbursed for participation in the Program.

**X** \_\_\_\_\_ Date: \_\_\_\_\_

Your Signature