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ORTHOPAEDIC SECTION, APTA, INC.
2920 East Avenue South, Suite 200
La Crosse, Wisconsin 54601
800-444-3982
608-788-3965 FAX
www.orthopt.org

Supplemental Residency Education Curriculum Package Verification Form

Residency Program: ______________________________

Address: ______________________________

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Program Director/Coordinator: ______________________________

Phone Number: ____________________ E-mail: ____________________

Program Credentialed? Yes No

Program Developing? Yes No

If developing, anticipated date of application submission (Month/Year): ____________

Start/end date of program (month/year): ______________________________

DIRECTOR/COORDINATOR

Name: ______________________________

APTA #: __________ E-mail Address: ____________________

Mailing Address: ______________________________

____

Check one:
- ☐ Residency Supplements Only
- ☐ Entire Residency Curriculum (all 5 courses on CD, along with supplements for all courses)

Director/Coordinator Fees:
- ♦Residency Supplements Only (No fee)
- ♦Entire Residency Curriculum ($400 Orthopaedic Section Members)
- ♦Shipping and Handling $10.00 per curriculum package

APTA
American Physical Therapy Association

RESIDENT 1

Name: ____

APTA #: ______________________ E-mail address:______________________________

Mailing Address: ____

RESIDENT 2

Name: ____

APTA #: ______________________ E-mail address:______________________________

Mailing Address: ____

RESIDENT 3

Name: ____

APTA #: ______________________ E-mail address:______________________________

Mailing Address: ____

Resident Fees: $400 Orthopaedic Section Members
$10.00 Shipping and Handling per curriculum

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Please submit the following information with this form in order to process your Supplementary Residency Education Curriculum Package Verification Form. Send to ISC Managing Editor, Orthopaedic Section, APTA, Inc., 2920 East Avenue South, Suite 200, La Crosse, WI 54601 or fax to 608/788-3965.

Credentialed program:

1. Residency Class Schedule
2. Resident Contract/Appointment Letter

Developing program:

1. Detailed Program Outline
2. Residency Proposal

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PAYMENT INFO:

☐ Check enclosed (Payable to Orthopaedic Section, APTA)
☐ Credit card: MasterCard, Discover, American Express, Visa (circle one)

Credit card #: ______________________________

Expiration date: ______________________________

Signature of cardholder: ______________________________

Print name of cardholder: ______________________________

Billing address for credit card: ______________________________

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Registration fee: __________

Shipping and handling: __________

Membership fee: __________

TOTAL: __________