



# Therapeutic Shoe Fitter Competency Attestation

## ATTESTER INSTRUCTIONS

To meet the eligibility criteria for ABC's Certified Fitter-therapeutic shoes credential, each candidate is required to possess the knowledges and demonstrate sufficient competence in the areas detailed on this attestation form. The attester must be one of the following: an ABC certified orthotist, an ABC certified pedorthist, or a professional referral source\*.

\*Professional referral source is defined as any appropriately licensed healthcare prescriber who is familiar with the applicant's professional knowledge and skills.

**NOTE:** Please be advised that a **NO** answer in any of the Knowledge or Skill areas will prevent the application from being approved. The attester should address any areas that cannot be marked as **Yes** with the applicant prior to completing this Competency Attestation form.

Applicant's Name: \_\_\_\_\_

## COMPETENCY ASSESSMENT

Please complete the following related to the applicant's knowledge or competency in the following areas:

Does the applicant possess knowledge and understanding of:

Anatomy of the foot related to proper shoe fitting

Yes  No

Medical terminology as it relates to the provision of therapeutic shoes/inserts

Yes  No

Common foot pathologies and deformities

Yes  No

Patient evaluation techniques, including physical evaluation of the foot, skin/tissue evaluation, and identification of therapeutic shoe eligibility criteria

Yes  No

Measurement and fitting; including use of foot measurement tools, appropriate footwear selection for the diabetic foot, and shoe fitting

Yes  No

Materials and their properties specific to therapeutic footwear and prefabricated therapeutic inserts

Yes  No

Complications associated with the diabetic foot, including signs and symptoms and associated risk factors

Yes  No

Documentation requirements (eg., Medicare required documentation)

Yes  No

Practice Management (e.g., knowledge of reimbursement, patient confidentiality, federal and state rules, and regulations)

Yes  No

Has the applicant demonstrated competency in:

Interviewing patients and communicating with referral sources

Yes  No

Taking a basic patient history and performing a physical exam (e.g., previous use of diabetic shoes, other health issues present, skin/tissue evaluation, edema assessment)

Yes  No

Managing patients relative to their diagnosis and condition

Yes  No

Measuring for therapeutic shoes/inserts

Yes  No

Assessing the fit and function of the therapeutic shoes/inserts at initial or diagnostic fitting, including safe heat molding of the prefabricated inserts

Yes  No

Assuring appropriate fit and function of the therapeutic shoes/inserts at final fitting and delivery

Yes  No

Appropriate documentation methods using established record-keeping techniques

Yes  No

Providing follow-up care (e.g., determine fit/function of shoes/inserts, patient compliance, change in patient's condition)

Yes  No

Educating patients regarding safe usage, maintenance and hygiene issues related to therapeutic shoes/inserts

Yes  No

Use of universal precautions

Yes  No

**ATTESTATION:**

Applicant Name: \_\_\_\_\_

I attest that the applicant, in my opinion, possesses the moral character and professional standards required of ABC certificants. I further attest that the applicant has demonstrated knowledge and competency in all of the elements contained on this Attestation form and is capable of performing the functions listed above that are required of a Certified Fitter-therapeutic shoes.

Your Name: \_\_\_\_\_

Your certification number: CPO: \_\_\_\_\_ CO: \_\_\_\_\_ CPed: \_\_\_\_\_

For Referral Source, Credential: \_\_\_\_\_

Are you in good standing with ABC, or your professional credentialing body?  Yes  No  
(Good standing is defined as being current with annual renewal fees, complying with mandatory continuing education, and not currently under disciplinary sanction.)

Your current employer: \_\_\_\_\_

Daytime phone number: \_\_\_\_\_

Your employer during the period of this attestation: (if same, indicate same)

\_\_\_\_\_

Please indicate the time frame during which you supervised this applicant or have had familiarity of their knowledge and competency.

From: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Facility name and location: (If same, indicate same)

\_\_\_\_\_

Any act of falsification by the attester is a violation of the ABC Code of Professional Responsibility and shall be referred to the ABC Professional Discipline Committee or applicable credentialing body.

Signature of Attester: \_\_\_\_\_ Date: \_\_\_\_\_

**All sections of this form must be complete.**

**This Competency Assessment form must be included with the Certified Fitter-therapeutic shoes application.**



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