**AOBFP Approved OMT Hands-On Course Provider Application**

Thank you for expressing interest in becoming an AOBFP Approved Program Provider of hands-on OMT training.

**Approved Program Provider Benefits**

1. Approval, once granted, is for three years, beginning on the application’s approval date.
2. Approved OMT Hands-On Courses will appear on the AOBFP website as a resource for diplomates.
3. Approved Program Provider programs/courses will be promoted to OMT diplomates to use towards their Component 3 renewal requirements.

If your organization becomes an Approved Program Provider, the information in this document must be followed. An individual program will only be approved for hands-on OMT training CME hours if it meets the following guidelines.

1. Providers submitting program/course applications will submit one application for each activity.
2. Providers pay one (1) $600 application fee.
3. Approval, once granted, is for three (3) years, beginning on the application’s approval date.
4. Activities, once approved, may be offered an unlimited number of times within the specified approval period.
5. Retroactive approvals are not granted for any program at any time.

**A program can only be approved for hands-on OMT Training CME if:**

* The program follows the AOBFP-approved OMT course template. Each section must consist of both lecture-type instruction (EX: PowerPoint and discussion with Q&A); and Hands-On Training at the OMT Tables. This Hands-On Training at the OMT Tables will be done 1:1 and highlight the landmarks for the anatomic area(s) affected, and the area(s) to be treated. Each of the lecture sections may include, but not be limited to the approach to patient, differential diagnoses, indications and contraindications for OMT, instructions for changes in lifestyle (i.e., decreased lifting at work), instructions for home exercises and/or stretching to prevent relapses.
* The instructor-to-participant ratio must be a minimum of 1/8 (one instructor for every eight participants). This is to ensure participants receive specific individual instruction. This can include but is not limited to muscle energy, counterstrain, myofascial release and HVLA techniques.
* Instructors must be AOBFP certified in OMT and disclose any conflict(s) of interest.
* At the conclusion of each section, the participant will be able to demonstrate a level of manipulative skills that can be safely and appropriately applied in the treatment of patients.
* The program content must be free from any commercial bias.
* The AOBFP strongly encourages all programs to comply with relevant federal, state/provincial and local laws related to serving individuals with disabilities so that no one with a disability is excluded from participation.

**As an approved CME provider, you must:**

* Submit a copy of the agenda, with times of each session and content areas, for each event. This must be submitted to AOBFP 60 days prior to the event for the approval number of CME that can be offered.
* Use the following specific language in flyers or advertisements: “*This program is approved for X hours of hands-on OMT Training CME by AOBFP Provider #XXXXX*.” No other statement regarding AOBFP in advertising or flyers may be made.
* Monitor meeting attendance and provide reports as requested by AOBFP
* Maintain records of attendance and provide reports to TraCME, the American Osteopathic Association’s system for tracking and reporting physician CME.
* Provide attendees with course objectives and use course objectives to evaluate how objectives were met.
* Provide attendees with a certificate with your AOBFP provider number within 90 days of completion of the course free of charge.
* Provide hands-on OMT training hours only for programs meeting the criteria established by AOBFP.

**To apply to become an AOBFP Approved Program Provider the following items must be submitted:**

* a completed application at least 60 days in advance of the meeting or publication of promotional materials if AOBFP information is to be included, and
* $600 application fee, and
* a copy of the course curriculum, with times of each session and content areas

Once approval is granted, the organization/company will be issued a provider number and a memo to assist in meeting the obligations of this program during the approved period. Their contact information including a link to their website will be posted on the AOBFP website as a resource for diplomates.

If you have any questions, please contact Certification Director Deb Dupnik at ddupnik@osteopathic.org or (312) 202-8147.

**AOBFP Approved OMT Hands-On Course Provider Application**

**Organization Information:**

*Organization:*

*Contact Person:*

*Address:*

*City: State: Zip:*

*Phone Number:*

*Fax Number:*

*Email Address:*

*Web Site:*

*Title of Course:*

*Date of Course:*

*Time:*

*Location of Course:*

*Registration Link:*

**DISCLOSURE STATEMENT**

I certify that all information on this application is true and understand that if any information on the application is found to be falsified, misleading, or a misrepresentation of facts, the organization will be declared ineligible for CME provider status.

The organization agrees to comply with all AOBFP policies including integrating, contacting, reporting, and record-keeping related to all AOBFP educational programs.

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(Signature) (Print Name)

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(Title) (Date)

**□$600 Approved Program Provider Fee**

Approval, once granted, is for three years, beginning on the approval date of the application. Activities, once approved, may be offered an unlimited number of times within the three-year, specified approval period. Retroactive approvals are not granted for any program at any time.

**The non-refundable, $600 application fee must be submitted with the application. Payment may be made online using a major credit card.**

**Paying by Credit Card: □*MasterCard* □** ***Visa* □*American Express Discover***

***Credit Card Number:***

***Expiration Date:***

***CVV:***

***Name on Credit Card:***

***Billing Address:***

***City:***

***State:***

***Zip:***

My signature below authorizes AOBFP to charge my credit card the appropriate CME Provider nonrefundable application fee.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_