



# Mastectomy Fitter Competency Attestation

## SUPERVISOR INSTRUCTIONS

To meet the eligibility criteria for ABC's Certified Fitter-mastectomy credential, each candidate is required to possess the knowledges and demonstrate sufficient competence in the areas detailed on this attestation form. The supervisor must be a certified/licensed practitioner, mastectomy fitter or a professional referral source\*.

*\*Professional referral source is defined as any appropriately licensed healthcare provider who is familiar with the applicant's professional knowledge and skills. Complete Pages 1 and 3.*

**NOTE:** The supervisor should address any areas that cannot be marked as **Yes** with the applicant prior to completing this Competency Attestation form.

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

## KNOWLEDGE AND 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 the following:

Anatomy, including upper limb, spinal and the lymphatic system

Yes  No

Medical terminology

Yes  No

Pathologies related to post-mastectomy care

Yes  No

Tissue characteristics/management including post-surgical edema

Yes  No

Patient examination techniques

Yes  No

Measuring for post-mastectomy items including use of measurement tools and techniques

Yes  No

Fitting criteria related to post-mastectomy items

Yes  No

Documentation requirements (e.g., progress notes, 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 related to post-mastectomy care

Yes  No

Managing patients relative to their diagnosis and condition

Yes  No

Measuring patients for post-mastectomy items

Yes  No

Developing and implementing a treatment plan

Yes  No

Evaluating fit and function of post-mastectomy items

Yes  No

Appropriate documentation methods using established recordkeeping techniques

Yes  No

Providing follow-up care

Yes  No

Educating patients regarding safe usage, maintenance, and hygiene issues

Yes  No

Use of universal precautions

Yes  No

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## SUPERVISOR ATTESTATION

To be completed by a certified/licensed practitioner or a mastectomy fitter

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

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

Your practitioner or fitter certification/license number: \_\_\_\_\_

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.)

Current Employer: \_\_\_\_\_

City/State: \_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Please indicate the time frame during which this applicant obtained their experience hours.

From: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ To: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

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 elements contained on this attestation form and is capable of performing the functions listed above that are required of a Certified Fitter-mastectomy.

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

Signature of Supervisor: \_\_\_\_\_ Date: \_\_\_\_\_

**All sections of this form must be complete before the application is submitted.**

**This Competency Attestation form must be included with the Certified Fitter-mastectomy application.**

Effective January 1, 2022, ABC certified supervisors are eligible for four (4) Category II CEUs (up to two times per five-year cycle).

Do you wish for this form to be submitted for CEUs?  Yes  No



**American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc.**

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### PROFESSIONAL REFERRAL SOURCE ATTESTATION

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

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

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

Credential Type: \_\_\_\_\_ Certification/license number: \_\_\_\_\_

Are you in good standing with 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.)*

Current Employer: \_\_\_\_\_

City/State: \_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Please indicate the time frame during which you had familiarity of this applicant's knowledge and competency.

From: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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 elements contained on this attestation form and is capable of performing the functions listed above that are required of a Certified Fitter-mastectomy.

Any act of falsification by the attester shall be reported to their applicable credentialing body.

Attester's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**All sections of this form must be complete before the application is submitted.**

**This Competency Attestation form must be included with the Certified Fitter-mastectomy application.**



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