FCCPT
FOREIGN CREDENTIALING COMMISSION ON PHYSICAL THERAPY

Physical Therapist Credentials Evaluation
REQUEST FOR ACADEMIC CREDENTIALS VERIFICATION

SECTION ONE: FOR APPLICANT TO COMPLETE BEFORE SUBMITTING TO INSTITUTION

Name:			
	Last Name	First Name	Middle Name

Date of Birth:	Month:		Day:		Year:		File Number:	

Institution/School Attended: _____

Dates of Attendance: From*: _____ To*: _____
If unsure of exact date, please enter YEAR of attendance, at a minimum. (MM/DD/YYYY) (MM/DD/YYYY)

Name while attending Institution: _____
(if different from name above) Last First Middle

Applicant's Cell Phone: _____
(Include Country and Area/City Code)

Applicant's Email: _____

I hereby authorize the release of my educational records to the Foreign Credentialing Commission on Physical Therapy (FCCPT).

_____ _____
Applicant Signature Date

SECTION TWO: FOR INSTITUTION TO COMPLETE BEFORE SUBMITTING TO FCCPT (CONTINUED ON PAGE 2)

Directions to Registrar: Please send this form along with the educational records (transcripts/marksheets/grade lists/etc.; detailed syllabus/detailed course content outlines; and certificate of clinical internship hours) of the applicant named above to:

FCCPT, 124 West Street South, 3rd Floor, Alexandria, VA 22314-2825

If there is no Registrar at the university or institution of higher learning, this form should be completed by the person charged with such duties. Should you have any questions please contact us at ***help@fccpt.org.***

Name of University/Institution: _____

Name/Title of Official Completing this form: _____

Institution Address: _____
Street City

_____
State/Province Post/Zip Code Country

Telephone: _____ Email: _____

CONTINUED ON PAGE 2

SECTION TWO: FOR INSTITUTION TO COMPLETE BEFORE SUBMITTING TO FCCPT (CONTINUED FROM PAGE 1)

Applicant's Name: _____
(as a student)

Name of Degree/Diploma Awarded: _____

Credential(s) Required for Program Admission: _____

Dates of Attendance: From: _____ To: _____
(MM/DD/YYYY) *(MM/DD/YYYY)*

Graduation Date: _____ Check this box if applicant did not graduate from this institution: ☐
(MM/DD/YYYY)

Length of Program: _____
(number of years)

Language of Instruction: _____ Language of Textbooks: _____

If applicant cannot be cleared for graduation at this time, please indicate the reason, e.g. all requirements for the certificate, diploma or degree have not been met and/or the individual has outstanding financial obligations to the institution.

_____

_____

_____

Signature and Seal are required for completion of this form

I hereby attest that my responses are complete and accurate to the best of my knowledge. In witness whereof, I hereby set my hand and seal of this institution this _____ day of _____, 20_____.

Registrar's Name, or other Official: _____
(Please Print)

Registrar's /Official's Signature: _____
(Affix Official Seal or Stamp)

Please include ALL educational records belonging to the applicant named on this form. Records may include Transcripts, Transcript of Hours, Marksheets*, and/or Grade Lists; Detailed Syllabus or Detailed Course Outlines; and Certificate of Clinical Internship Hours.

******Note:* **Marksheets must come with corresponding Transcript of Hours in order to be accepted for evaluation purposes.**