FCCPT
FOREIGN CREDENTIALING COMMISSION ON PHYSICAL THERAPY

New York State Credentials Verification

REQUEST FOR LICENSE/REGISTRATION VERIFICATION

FOR APPLICANT TO COMPLETE AND SUBMIT TO FCCPT			
Name:			
	Last Name	First Name	Middle Name

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

Name of Licensing Board or Registration Authority: _____

Name of Recipient at Licensing/Registration Authority: _____

Licensing Board Address: _____
Street City

_____
State/Province Post/Zip Code Country

Applying to the New York State Education Department (NYSED) for licensure as a: _____
Profession

The Foreign Credentialing Commission on Physical Therapy (FCCPT) has been authorized by the New York State Education Department to obtain and verify my licensure, registration, or other record indicating my eligibility to practice the profession stated above.

Please provide verification of my license/registration to practice within your state, country, or other jurisdiction, to FCCPT by COMPLETING THE ENCLOSED NEW YORK STATE LICENSE VERIFICATION FORM and submitting the completed form to:

Foreign Credentialing Commission on Physical Therapy
124 West Street South, 3rd Floor
Alexandria, Virginia 22314-2825

License Number: _____

Date of Licensure/Registration*: _____
(MM/DD/YYYY)
*If unsure of exact date, please enter attendance YEAR, at a minimum.

Name when license was issued: _____
(if different from name above) Last First Middle

Home Phone: _____ Work Phone: _____
(Include Country and Area/City Code for Home and Work)

Email: _____

I hereby authorize the release of my licensure, registration, or other records indicating my eligibility to practice within your country, state, or other jurisdiction, to the Foreign Credentialing Commission on Physical Therapy (FCCPT).

_____ _____
Applicant Signature Date

LICENSING AUTHORITY: PLEASE COMPLETE THE ENCLOSED *NEW YORK STATE LICENSE/REGISTRATION VERIFICATION* AND SUBMIT TO FCCPT.