

FOREIGN CREDENTIALING COMMISSION ON PHYSICAL THERAPY (FCCPT)

Physical Therapist Credentials Evaluation
REQUEST FOR VERIFICATION OF PHYSICAL THERAPY LICENSE
(For completion by applicant)

Directions: Please complete this form and send it, along with the *Verification of Physical Therapy License*, to the appropriate regulatory authority that will verify your license to practice physical therapy. Include an envelope addressed to FCCPT, 124 West Street South, Alexandria, Virginia 22314-2825, USA.

Attention: Licensing Board, Government Agency or other Organization,

State/Country/Other Jurisdiction

Please verify to the Foreign Credentialing Commission on Physical Therapy, on the enclosed *Verification of Physical Therapy License* form or on your own form currently in use for this purpose, my license, registration or other record indicating my eligibility to practice physical therapy within your state, country or other jurisdiction.

I hereby authorize the verification of my licensure, registration or other record indicating my eligibility to practice physical therapy within your state, country or other jurisdiction to the Foreign Credentialing Commission on Physical Therapy.

Signature: _____ Date: _____

Personal Information:

Name: _____
Last First Middle

Name under which license was issued, if different from the above:

Last First Middle

Physical Therapy License Number: _____

Date of Birth: _____ Home Phone: _____
(Month/Day/Year) (Include country and area/city code)

Work Phone: _____ E-mail: _____
(Include country and area/city code)

NOTE: If you do not hold a license, please mark the following box, place your signature on the line provided, and return this form to FCCPT.

I DO NOT HOLD ANY LICENSE FOR PHYSICAL THERAPY.

Signature Date

Physical Therapist Credentials Evaluation
VERIFICATION OF PHYSICAL THERAPY LICENSE
(For completion by appropriate regulatory authority)

Directions for regulatory authority: Please send this form or an appropriate substitute currently in use by your organization for this purpose to FCCPT, 124 West Street South, Alexandria, Virginia 22314-2825, USA. Should you have any questions please contact FCCPT at: Telephone, 703-684-8406; Fax, 703-684-8715; or E-mail, help@fccpt.org.

Regulatory Authority: _____

Address: _____

Telephone: _____ Fax: _____ E-mail: _____

Applicant's Name: _____ Date of Birth: _____
(Month/Day/Year)

The above named person held/holds a license, is registered or is otherwise authorized to practice physical therapy by the above name regulatory authority from _____ to _____.
(Month/Day/Year) (Month/Day/Year)

Status of License/Registration/Other (Check One):

_____ Active/Current _____ Expired _____ Inactive _____ Restricted*

*If the applicant's license to practice physical therapy has ever been revoked, suspended, limited, or placed on probation, please attach documentation describing the reason for such action.

Signature is 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____.

Signature of Official completing this form: _____

Print Name of Official completing this form: _____

Title of Official completing this form: _____
(Affix Official Seal or Stamp)

