FCCPT
FOREIGN CREDENTIALING COMMISSION ON PHYSICAL THERAPY

New York State Credentials Verification

REQUEST FOR LICENSE/REGISTRATION VERIFICATION

FOR APPLICANT TO COMPLETE AND SUBMIT TO EACH LICENSING BOARD/REGISTRATION AUTHORITY			
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: _____

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

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
help@fccpt.org

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

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

Applicant's 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.

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New York State Credentials Verification
LICENSE/REGISTRATION VERIFICATION FORM

FOR LICENSING, REGISTERING, OR OTHER AUTHORITY TO COMPLETE AND SUBMIT TO FCCPT

Directions to Licensing/Registration Official: Please complete and send this form to:
FCCPT, 124 West Street South, 3rd Floor, Alexandria, VA 22314-2825
Should you have any questions please contact us at ***help@fccpt.org.***

Name of Licensing/Registration Authority: _____

Name/Title of Official Completing this form: _____

Institution Address: _____
Street City

_____
State/Province Post/Zip Code Country

Email: _____

Applicant's Name: _____
(as licensed / registered)

The individual named above held/holds a license, is registered, or is otherwise authorized to practice physical therapy by the regulatory authority named above **from:** **to:**

_____ _____
(MM/DD/YYYY) *(MM/DD/YYYY)*

Status of License/Registration: *(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 describe the reason below and/or attach documentation describing the reason for such action.

_____

_____

_____

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_____.

Name of Official completing this form: _____
(Please Print)

Signature of Official completing this form: _____

(Affix Official Seal or Stamp)