FCCPT
FOREIGN CREDENTIALING COMMISSION ON PHYSICAL THERAPY

CHANGE OF SERVICE REQUEST FORM

Name:			
	Last Name	First Name	Middle Name

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

INSTRUCTIONS

Please fill in all of the information below in order to process your Change of Service request. Email or mail completed form to:

FCCPT
124 West Street South, 3rd Floor
Alexandria, VA 22314-2825, USA
Email: help@fccpt.org

Current Service: _____

Service you would like to change to: _____

TERMS AND CONDITIONS

1. A service fee will be applied if changing a service after five (5) business days from the submission of your application.
2. If the new service you are requesting has a higher fee than your current service, you will be responsible to pay the difference within thirty (30) business days after notification of completion of your change of service.
3. If it has been more than five (5) days since the submission of your application and the new service you are requesting has a lesser fee than your current service, you will NOT be refunded the difference in cost. The difference will not be applied to the change of service fee, and you are responsible to pay the full amount due within thirty (30) business days.

ATTESTATION

Note: Do not submit this form unless you understand and agree to the following terms.

1. I certify that I am the applicant named on this form.
2. I acknowledge that the attestation signed when I submitted my application is still in force and that this document is intended to correct information mistakenly entered or adjust my application to the service that best meets my needs.

This form will not be processed without your signature.

_____ _____

Signature Date