FCCPT
FOREIGN CREDENTIALING COMMISSION ON PHYSICAL THERAPY

CLINICAL INTERNSHIP FORM

Name:			
	Last Name	First Name	Middle Name

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

INSTRUCTIONS FOR APPLICANT

Please fill in all of the information on this page before sending the form to your school. Mail completed form to your school.

Institution/School Attended:	

Dates of Attendance:		
	From: mm/dd/yyyy	To: mm/dd/yyyy

Name While Attending Institution:			
	Last Name	First Name	Middle Name

I hereby authorize the release of my educational records to the Foreign Credentialing Commission on Physical Therapy (FCCPT). Please complete the enclosed Clinical Internship Form and include with my documents.

Applicant Signature: _____ Date: _____

FOREIGN CREDENTIALING COMMISSION ON PHYSICAL THERAPY

CLINICAL INTERNSHIP FORM

INSTRUCTIONS FOR SCHOOL

Please mail all pages of this form directly to FCCPT along with the clinical internship information to the address below:

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

This form should be completed by the person charged with administering the clinical internship experiences of physical therapy students. Should you have any questions, please contact us at: help@fccpt.org.

Applicant Name:			
	Last Name	First Name	Middle Name

Name of Degree/Diploma Awarded:	

Total Number of Clinical Internship Hours Completed:	

Clinical Internship Placements/Settings:				
1.				
	Placement/Setting Description	Number of Hours	From: mm/dd/yyyy	To: mm/dd/yyyy
2.				
	Placement/Setting Description	Number of Hours	From: mm/dd/yyyy	To: mm/dd/yyyy
3.				
	Placement/Setting Description	Number of Hours	From: mm/dd/yyyy	To: mm/dd/yyyy
4.				
	Placement/Setting Description	Number of Hours	From: mm/dd/yyyy	To: mm/dd/yyyy
5.				
	Placement/Setting Description	Number of Hours	From: mm/dd/yyyy	To: mm/dd/yyyy
6.				
	Placement/Setting Description	Number of Hours	From: mm/dd/yyyy	To: mm/dd/yyyy
7.				
	Placement/Setting Description	Number of Hours	From: mm/dd/yyyy	To: mm/dd/yyyy

FOREIGN CREDENTIALING COMMISSION ON PHYSICAL THERAPY

CLINICAL INTERNSHIP FORM

Name of University/Institution: _____

Name/Title of Official Completing this form: _____

Institution Address: _____
(Street) (City)

_____
(State/Province) (Post/Zip Code) (Country)

Telephone: _____ Email: _____

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.

Official's Name (Please Print):_____

Official's Signature: _____

Date: _____

(Affix Official Seal or Stamp)