FCCPT
FOREIGN CREDENTIALING COMMISSION ON PHYSICAL THERAPY

Physical Therapist Credentials Evaluation
POST-GRADUATE CLINICAL WORK EXPERIENCE VERIFICATION FORM

Instructions and Guidelines:

This form is to be used to authenticate the clinical work experience for graduates of international physical therapy programs that are not accredited by the Commission on Accreditation of Physical Therapy Education (CAPTE) and who did not have evidence of a minimum of 1,050 Hours of full-time clinical experience within the curriculum.

The form is to be completed by a representative of the facility where the hours were worked, preferably the supervisor, with direct knowledge of, or the ability to confirm, the patient care hours for the physical therapist applying for credentialing for U.S. licensure. The maximum number of hours that that can be considered is 300 hours.

The following post-graduate clinical experience hour requirements must be met to be considered:

1. Completed an average of at least 20 hours per week for a minimum of 1,000 hours.
2. Completed 1,000 hours in direct patient care.
3. Completed the hours within the most recent three years preceding the application.
4. Completed the hours within a hospital, rehabilitation center, or other facility that employed a minimum staff of at least three (including the applicant) practicing physical therapists during the applicant's clinical experience hours.
5. A physical therapist employed at the facility with the applicant must have been available for consultation.
6. At least one of the physical therapists employed at the facility with the applicant must have at least two years of experience practicing as a physical therapist.
7. Verification that the applicant was eligible to practice in the country in which the experience was completed.
8. Verification that the applicant has had no disciplinary action against any professional license held for at least three years.
9. This form must be submitted directly to FCCPT by the supervisor completing this form.

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Name:			
	Last Name	First Name	Middle Name

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

1. Name and title/position of direct supervisor:
   _____ ☐ PT ☐ PTA Other _____
   Email address of supervisor: _____
2. Name and title/position of the person completing this form: *(if different from direct supervisor)*
   _____ ☐ PT ☐ PTA Other _____
3. Name of the facility _____
   Address of facility _____
   a. Type of facility (i.e., hospital, private clinic, etc.): _____
   b. Applicant's dates of employment in facility as a physical therapist (from_____ to_____)
   c. Average hours/week worked in ***direct patient care*** as a physical therapist _____
   d. Total Hours worked ***in direct patient care*** by applicant as a physical therapist, in the 3 years immediately prior to submission of this form: _____
4. Phone Number of facility: _____
5. Website of facility: _____
6. List of physical therapists that worked at the facility **with** the applicant (use additional pages if needed)

Name	Title/Position	Years of Experience as a PT

7. Based upon the performance of _____, the applicant ☐ ☐ **has/has not (check one)**
   (Name of Applicant)
   exhibited safe and effective care as a physical therapist.
8. To my knowledge, _____ ☐ ☐ **has/ has no (check one)** disciplinary actions or
   (Name of Applicant)
   complaints filed within the past three (3) years on any professional license.

   I, _____, hereby certify that I am the person who completed the attached form
   (Print Name)
   regarding post-graduate clinical work experience for _____;
   (Name of Applicant)
   and that all statements and documents enclosed herein are true.

   _____
   Signature