FOREIGN CREDENTIALING COMMISSION ON PHYSICAL THERAPY

TYPE 1 REVIEW FOR LICENSURE ONLY

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 request to proceed with the Comprehensive Credentials Review (Type 1 Review) FOR THE PURPOSE OF LICENSURE ONLY. Upload here or mail completed form to:

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

State/Jurisdiction for which you are applying for Licensure: _____

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 understand that the result of my Type 1 Review will NOT meet the requirements necessary to obtain a Healthcare Worker Certificate (Type 1 Certificate) and that the evaluation report obtained will be valid for licensure only.
3. I acknowledge that the attestation signed when I submitted my application is still in force and that this document is intended to correct information omitted at the time of the application.

This information will not be processed without your signature.

_____ _____

Signature **Date**