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: _____**

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# 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 |

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# 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)*