FCCPT
FOREIGN CREDENTIALING COMMISSION ON PHYSICAL THERAPY

Physical Therapist Credentials Evaluation

REQUEST FOR VERIFICATION OF PT LICENSE/REGISTRATION

SECTION ONE: FOR APPLICANT TO COMPLETE BEFORE SUBMITTING TO INSTITUTION

Name:			
	Last Name	First Name	Middle Name

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

Directions for Applicant: Please complete Section One of this form and send to the appropriate regulatory authority that will verify your license to practice physical therapy. Include an envelope addressed to FCCPT, 124 West Street South, Alexandria, Virginia 22314-2825, USA.

If you do not hold a license to practice, mark the box below and submit directly to FCCPT.

Licensing/Registration Authority: _____

Name under which license was issued: _____
(if different from name above) Last First Middle

License Number: _____

If you do not hold a license, please mark the following box and return this form, with signature, to FCCPT: ☐

Applicant's Cell Phone: _____
(Include Country and Area/City Code)

Applicant's Email: _____

I hereby authorize the verification of my licensure, registration, or other record indicating my eligibility to practice physical therapy within your state, country, or other jurisdiction to the Foreign Credentialing Commission on Physical Therapy (FCCPT).

_____ _____
Applicant Signature Date

SECTION TWO: FOR INSTITUTION TO COMPLETE BEFORE SUBMITTING TO FCCPT (CONTINUED ON PAGE 2)

Directions for Regulatory Authority: Please send this form, or an appropriate substitute currently in use by your organization for this purpose, to:

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

Should you have any questions please contact us at ***help@fccpt.org.***

Regulatory Authority: _____

Institution Address: _____
Street City

_____
State/Province Post/Zip Code Country

Telephone: _____ Email: _____

Applicant's Name: _____
(As Licensed/Registered)

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SECTION TWO: FOR INSTITUTION TO COMPLETE BEFORE SUBMITTING TO FCCPT (CONTINUED FROM PAGE 1)

The individual named above held/holds a license, is registered, or is otherwise authorized to practice physical therapy by the regulatory authority named above **from:** _____ *(MM/DD/YYYY)* **to:** _____ *(MM/DD/YYYY)*

Status of License/Registration: *(Check One)* ☐ Active / Current ☐ Expired ☐ Inactive ☐ Restricted*

* If the applicant's license to practice physical therapy has ever been revoked, suspended, limited, or placed on probation, please attach documentation describing the reason for such action.

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. In witness whereof, I hereby set my hand and seal of this institution this _____ day of _____, 20_____.

Name/Title of Official Completing this form: *(Please Print)* _____

Signature of Official Completing this form: _____ *(Affix Official Seal or Stamp)*