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 1050 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 signature of both the representative and applicant are to be notarized, attesting to the truthfulness of the statements in the form. The maximum number of hours that may be considered is 300 hours.

Please note that both the applicant and supervisor must complete the attached attestations and have them notarized. The attestations do not have to be notarized at the same time, or in the same country.

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

1. **Must have the approval of the jurisdiction in which you are seeking licensure.**
2. Completed an average of at least 20 hours per week for a minimum of 1,000 hours.
3. Completed 1,000 hours in direct patient care.
4. Completed the hours within the most recent three years preceding the application.
5. 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 therapist during the applicant's clinical experience hours.
6. A Physical Therapist employed at the facility with the applicant must have been available for consultation.
7. At least one of the physical therapist employed at the facility with the applicant must have at least two years of experience practicing as a physical therapist.
8. Verification that the applicant was eligible to practice in the country in which the experience was completed.
9. Verification that the applicant has had no disciplinary action against any professional license held for at least three years.
10. Notarized verification of the work experience provided by a supervisor such as the department head of the physical therapy practice or the director/head of the facility.
11. This form must be submit directly to FCCPT by the supervisor completing this form.

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Physical Therapist Credentials Evaluation

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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 _____

   a. 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 PT (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 (circle one)**
   (Name of Applicant)

   exhibited safe and effective care as a Physical Therapist.

8. To my knowledge, _____**has/ has no (circle one)** disciplinary actions or
   (Name of Applicant)

   complaints filed within the past three (3) years on any professional license.

Attestation Statements

Attestation of Person Completing Form ***(Requires Notary Seal and Signature)***

I, _____, hereby certify under oath 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

Subscribed and sworn before me, _____ this _____ day of _____, 20 ____,
(Print Name of Notary)

in the Country of _____, State of _____, City of _____.

_____
Signature of Notary

(Affix Seal Here)

Attestation Statements

Attestation of Applicant (*Requires Notary Seal and Signature)*

I, _____, hereby certify under oath that, to the best of my knowledge, all
(Print Name)

statements and documents enclosed herein as part of the Post-Graduate Clinical Work Experience Verification Form are true.

_____
Signature

Subscribed and sworn before me, _____ this _____ day of _____, 20 ____,
(Print Name of Notary)

in the Country of _____, State of _____, City of _____.

_____
Signature of Notary

(Affix Seal Here)