



Application for Physical Therapist or Physical Therapist Assistant Licensure

Board of Physical Therapy
P.O. Box 6330
Tallahassee, FL 32314-6330

Website: floridasphysicaltherapy.gov

Email: info@floridasphysicaltherapy.gov

Phone: (850) 245-4373

Fax: (850) 414-6860



Are you an active duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered "Yes" to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health's commitment to serving members and veterans of the United States Armed Forces and their families online at <http://www.flhealthsource.gov/valor>

Important Information:

Candidates are required to provide **current and valid** forms of identification (ID) to be able to sit for the examination. Acceptable forms of ID are currently valid, government-issued photo ID (passport, driver's license, etc.), and another piece of identification pre-printed with your name containing your signature, such as a credit card. Your signature must match your pre-printed name on both forms of ID. A Social Security card is not an acceptable form of identification. As part of your identification processing, the driver's license/passport will be swiped in order to retain scanned information.

Applicants must provide the full name that appears on the valid form of Identification (ID) that they will present at the Prometric Testing Center, on their application. Variations in names will cause delays in approval and possibly denial of entry at the testing site to take the examination.



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Do Not Write in this Space
For Revenue Receiving Only

Select one application type:

- Physical Therapist (5501)
- Physical Therapist Assistant (5502)

Select one method of licensure:

- Examination with Temporary Permit \$180.00
- Exam without Temporary Permit \$180.00
- Endorsement \$180.00

Total fee of \$180.00 includes the following:

Application Fee	\$100.00
Licensure Fee	\$75.00
Unlicensed Activity Fee	\$5.00

I have registered with the FSBPT (<https://www.fsbpt.org>) for the NPTE and/or laws exam.

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health.
Application fees are non-refundable.

1. PERSONAL INFORMATION

Name: _____ Date of Birth: _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

Street/P.O. Box Apt. No. City

State ZIP Country Home/Cell Telephone (Input without dashes)

Practice Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website)

Street Suite No. City

State ZIP Country Work/Cell Telephone (Input without dashes)

EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: Male	Race: Native Hawaiian or Pacific Islander	Hispanic or Latino	White
Female	American Indian or Alaska Native	Black or African American	Asian
	Two or More Races		

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

Yes No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statute (F.S.), authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

Social Security Number: _____
(Input without dashes)

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, §§ 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, F.S. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

3. SPECIAL TESTING ACCOMMODATIONS

Applicants must have a qualifying medical condition in order to receive special testing accommodations. Applicants requiring special accommodations should **verify that the accommodations are available prior to scheduling their examination.**

Do you require special testing accommodations? **Yes** **No**

Applicants who require special testing accommodations should be aware that the process to have accommodations approved is quite lengthy, usually taking a minimum of 60 days. To apply for special accommodations, download the information booklet at <https://floridasphysicaltherapy.gov/applications/booklet-special-testing-accommodations.pdf> or contact the Special Testing Coordinator at (850) 245-4252. **Accommodation requests must be sent to:**

**Department of Health, Division of Medical Quality Assurance
Bureau of Operations, Attention: ADA Accommodations
4052 Bald Cypress Way, Bin C-91
Tallahassee, FL 32399-3250**

Name: _____

4. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

B. Have you ever applied for a physical therapist or a physical therapist assistant license in the state of Florida?
Yes No

If "Yes," provide date previously applied and indicate the method you applied under.

Date: _____ Method: Examination Endorsement
MM/DD/YYYY

C. Do you hold, or have you ever held a temporary permit, license/certification, or other authorization, regardless of status, to practice physical therapy or any health-related profession in any state (including Florida), U.S. territory, or foreign country? Yes No

D. List all health-related licenses (active, inactive or lapsed).

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

Board staff will attempt to locate online verifications that contain any disciplinary history for each license ever held. If the disciplinary history information is not available online, applicants will be required to request an official verification. License verifications must be received directly from the licensing authority regardless of the status of the license. **A copy of your license will not be accepted** in lieu of official verification from the licensing agency.

All endorsement applicants must hold an **active** license in another state.

Endorsement applicants who were educated outside the United States must submit documentation for one of the following options:

Option 1: A credentials evaluation completed **specifically for Florida** that demonstrates the applicant meets minimum qualifications.

OR

Option 2: If the applicant **has five years of clinical experience**, they may submit the following:

- A certified copy of the credential evaluation used by the physical therapist/assistant licensing board of another state. The evaluation must be on the appropriate coursework tool (CWT) adopted by the Federation of State Boards of Physical Therapy (FSBPT) and reflect the education criteria in place at the time of graduation
- Proof of 1,000 clinical practice hours each year in the United States for five out of the last ten years. Full-time teaching of physical therapist/assistant education may count toward 250 of the 1,000 required practice hours per year.

5. DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? Yes No

Name: _____

6. EDUCATION HISTORY

A. List in chronological order school, colleges, and universities attended.

School Name and Location	Graduation Date (MM/DD/YYYY)	Degree Awarded	Major

B. What name(s) did you use when you received your physical therapist education?

Applicants educated in the United States or Accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE) must have received a degree in physical therapy (PT) or as a physical therapy assistant (PTA) from an institution that has been approved by the appropriate accrediting agency in accordance with s. 486.031, F.S. or s. 486.102, F.S. The institution must have been approved at the time of graduation.

All applicants must have an official transcript forwarded directly to the board office from the United States educational institution. Transcripts must indicate the graduation date, degree earned, and be embossed with the school seal. Diplomas and student copies are not acceptable.

For a physical therapist or physical therapist assistant to be approved to take the licensure examination the Board must receive verification that the applicant has graduated. The applicant's institution may send a final transcript, or the applicant's program may send a Letter of Completion, **the letter must contain the following:**

- a. Be sent to the Board directly from the educational institution,
- b. Be presented on official school letterhead,
- c. Confirm that the individual completed all clinical and didactic requirements of their specified degree,
- d. State the date the individual earned their degree, and
- e. Be signed and dated by the program director or the school registrar.

Applicants educated outside the United States must submit a credential evaluation. This requirement applies even if the applicant has received a transitional Doctorate of Physical Therapy from a U.S. school.

PTA applicants must have graduated from a school giving a course for physical therapist assistants outside of the U.S. Applicants **may not** use a physical therapist degree to apply as a physical therapist assistant. See Rule 64B17-3.001, Florida Administrative Code (F.A.C.) for more information.

The board currently accepts evaluations from:

Foreign Credentialing Commission on Physical Therapy (FCCPT)
124 S West St.
Alexandria, VA 22314
(703) 684-8406
Email: help@fccpt.org

International Education Research Foundation
P.O. Box 3655
Culver City, California 90231-7086
(310) 258-9451
website: www.ierf.org

International Consultants of Delaware, Inc. (ICD)
3600 Market Street Suite 450
Philadelphia, PA 19104, USA
Phone: (215) 222-8454 ext. 510
Fax: (215) 349-0026
Email: icd@icdel.com
Web: www.icdeval.com

Name: _____

7. EXAMINATION HISTORY

National Physical Therapy Exam (NPTE)

Have you taken the NPTE, whether passed or failed? Yes No

If “No,” visit www.fsbpt.org for registration and exam information. Note that the NPTE exam fee must be paid directly to the Federation of State Board of Physical Therapy (FSBPT).

An additional Prometric Testing Center fee is required at the time of scheduling, paid directly to the Prometric Testing Center. Visit <https://www.prometric.com/test-takers/search/abpts> for fee and payment information.

If “Yes,” provide the following information for each jurisdiction in which the examination was taken:

Examination Type	State/Country	Examination Date (MM/YYYY)	Results
PT PTA			
PT PTA			
PT PTA			

Any applicant who applies through Florida and has failed the NPTE exam three times in any jurisdiction must complete a board-approved remedial training course after the third attempt, prior to being seated for the NPTE on the fourth attempt, as outlined in 64B17-3.002, F.A.C.. Per the FSBPT, candidates may only take the NPTE exam three times in any 12-month period.

Examination Type	State/Country	Examination Date (MM/YYYY)	Results
PT PTA			
PT PTA			

Per s. 486.051 and 486.104, F.S., an applicant who has failed to pass the NPTE exam after five attempts, regardless of the jurisdiction, is no longer eligible to take the examination.

Applicants who have passed the NPTE must have their score report transferred to Florida from the FSBPT. Visit www.fsbpt.org for information on the FSBPT's score transfer service.

Florida Laws and Rules Exam

All applicants are required to pass the Florida Laws and Rules exam prior to licensure. The exam will be given through FSBPT and will cover chapters (ch.) 456 and 486, F.S., and Rule 64B17, F.A.C.

The exam fee must be paid directly to the FSBPT. Visit www.fsbpt.org for exam registration and fee information.

An additional Prometric Testing Center fee is required at the time of scheduling, paid directly to the Prometric Testing Center. Visit www.prometric.com for fee and payment information.

Applicants requesting a temporary permit must take and pass the Florida Laws and Rules exam before the permit may be issued.

This information is exempt from public records disclosure.

8. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

- A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? Yes No
- B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? Yes No

Substance-Related Disorders Impacting Ability to Practice

- C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice? Yes No
- D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse? Yes No
- E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? Yes No

If a “Yes” response was provided to any of the questions in this section, provide the following documents directly to the board office:

A letter from a Licensed Health Care Practitioner, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

A written self-explanation, identifying the medical condition(s) or occurrence(s); and current status.

Name: _____

9. DISCIPLINE HISTORY

- A. Have you ever had a health care license to practice any profession revoked, suspended, or otherwise acted against in, including denial of licensure, a disciplinary proceeding in any state, territory, or country?
Yes No
- B. Have you ever been disciplined, terminated or allowed to resign, in lieu of termination, from an employment setting where employed as a physical therapist or physical therapy assistant, or in any capacity in any other health care profession? Yes No
- C. Have you ever been named, sued for, or found guilty of malpractice? Yes No
- D. Have you ever been notified to appear before any licensing authority on a complaint of any nature, including, but not limited to a charge or violation for unprofessional or unethical conduct? Yes No

If you responded "Yes" to any of the questions in this section, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				Y N
				Y N
				Y N

If you responded "Yes" to any of the questions in this section, you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding the disciplinary action.

A copy of the **Administrative Complaint and Final Order**.

10. CRIMINAL HISTORY

- A. Have you ever been convicted or found guilty, regardless of adjudication, of a crime in any jurisdiction which directly relates to the practice of physical therapy? Yes No
- B. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld.

Reckless driving, driving while license suspended or revoked (DWSLR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question. Yes No

If you responded "Yes" to any of the questions in this section, you must provide the following:

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				Y N
				Y N
				Y N

If you responded "Yes" in this section, you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.

Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

Completion of Sentence Documents. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

Name: _____

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? Yes No

If you responded “No” to the question above, skip to question 5.

- a. Have you been in good standing with a state Medicaid program for the most recent five years?
Yes No
- b. Did termination occur at least 20 years before the date of this application? Yes No
5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? Yes No
- a. If you responded “Yes” to the question above, are you listed because you defaulted or are delinquent on a student loan? Yes No
- b. If you responded “Yes” to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? Yes No

If you responded “Yes” to any of the questions in this section, you must provide the following:

A written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation.

Supporting documentation including court dispositions or agency orders where applicable.

All documentation must be mailed to:

Board of Physical Therapy
4052 Bald Cypress Way Bin C-05
Tallahassee, FL 32399-3255

Name: _____

12. REQUEST FOR TEMPORARY PERMIT – FOR EXAM APPLICANTS ONLY (OPTIONAL)

Per s. 486.0715 and 486.1065, F.S., applicants requesting a temporary permit must provide proof of the following requirements:

Graduation from an approved United States physical therapy/physical therapist assistant educational program as applicable and meet all eligibility requirements for licensure, except passage of the national examination. **Physical therapist applicants** refer to ch. 456 and s. 486.031(1)-(3)(a) F.S.; **physical therapist assistant applicants** refer to ch. 456 and 486.102(1)-(3)(a), F.S.

Passage of the Florida Laws and Rules Examination.

Scheduled NPTE date: _____
MM/DD/YYYY

Possession of malpractice insurance

Malpractice Insurance Information	
Insurer:	
Policy #:	
Effective Date: (MM/DD/YYYY)	Expiration Date: (MM/DD/YYYY)

Verification that the applicant will practice under direct supervision of a licensed physical therapist.

Supervisor Information
A supervising physical therapist can only supervise one permittee at any given time. The supervising physical therapist must be licensed for a minimum of six months before the supervision period begins and must cosign all patient records produced by the physical therapist practicing under a temporary permit. It is the applicant's responsibility to ensure the supervising physical therapist is aware of these requirements.
Name of Florida-licensed PT Supervisor:
License Number:
License Issue Date (MM/DD/YYYY):
Phone Number (Input without dashes):

An applicant for a temporary permit **may not** work as a physical therapist or a physical therapist assistant until a temporary permit is issued by the board. The permittee must practice under the direct supervision of a licensed physical therapist. A temporary permit is **not** renewable and is valid until a full license is granted by the board. A temporary permit is voided if the permittee does not pass the NPTE within six months after the date of graduation.

Name: _____

13. APPLICANT SIGNATURE

I hereby authorize all hospitals, institutions, or organizations, personal physicians, employers (past or present), business and professional associates (past or present), and all governmental agencies and instrumentality's (local, state, federal, or foreign) to release to the Department of Health any information, files, or records requested by the department in connection with the processing of this application. I further authorize the department to release to the organizations, individuals, and groups listed above any information for which is material in my application.

I understand that it is my duty and responsibility as an applicant for licensure to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the board's decision concerning my eligibility for examination or licensure. Such supplement is required under ch. 456.013(1)(a), F.S. Failure to do so may result in disciplinary action by the board including denial of licensure.

I have carefully read the questions in the foregoing application and have answered them completely without reservation of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information on this application, I hereby acknowledge that such act shall constitute cause for denial, suspension, or revocation of any license to practice in the state of Florida for the profession for which I am applying. I declare that I am the person referred to in the foregoing application. I further state that I will comply with all requirements for licensure renewal in effect at the time of license renewal including submission of appropriate renewal fees and continuing education credits.

Under penalties of perjury, I declare that I have read the foregoing document, and the evidence presented herein for the purpose of demonstrating, to the satisfaction of the board, that I possess the qualifications preliminary to examination required by s. 486.041 and 486.103, F.S., or that I possess licensure in another state, the district of Columbia, or a territory as required by s. 486.081 and s. 486.107, F.S., is true.

I hereby acknowledge that practice as a physical therapist and physical therapy assistants in Florida is governed by ch. 456 and 486, F.S., and Rule Title 64B17, F.A.C. I understand that I am under a continuing obligation to understand and keep informed of any changes to the aforementioned statutes and rules.

Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____
You may print this application and sign it or sign digitally. MM/DD/YYYY

Applicants may not begin employment in Florida as a physical therapist or physical therapist assistant until they have received their Florida license.

The Candidate Information Booklet for the Physical Therapy Laws and Rules Computer Based Testing Examination may be obtained on our website at: <https://floridaphysicaltherapy.gov/forms/pt-study.pdf>.

The FSBPT Laws and Rules Exam fee must be paid directly to the FSBPT. Please visit www.fsbpt.org for fee and payment information.

The Prometric Testing fee must be paid directly to the Prometric Testing Center at the time of scheduling. Visit <https://www.prometric.com/test-takers/search/abpts> for fee and payment information.

Complete verifications must be mailed directly from the licensing agency to:

Board of Physical Therapy
4052 Bald Cypress Way Bin C-05
Tallahassee, FL 32399-3255



Physical Therapist License Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: _____

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

I hereby authorize release of any information regarding my licensure status to the Physical Therapy Board.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

- * Typed on an official state form or letterhead
- * Include an official board seal
- * Signature and title of state board official

The following information must be included in all verifications:

- * Licensee name
- * License number
- * State or jurisdiction of licensure
- * Licensure status
- * Is license in good standing?
- * Date of issuance and expiration
- * Licensure method (examination, grandfathering, reciprocity/endorsement) If exam, provide exam name, exam level, exam date, and score achieved.
- * Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
- * If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.