Re-Examination Application for Physical Therapist or Physical Therapist Assistant

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

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 Receipting Only

Applicants must re-register with the FSBPT online at www.fsbpt.net/pt and pay exam vendor fees, which are in addition to the fees paid to the board.

Physical Therapist (5501) **Physical Therapist Assistant** (5502)

Select the exam(s) to be retaken:

NPTE (1011) **$100.00**
I have registered online for the NPTE.

Florida Laws and Rules (1013) **No Fee**
I have registered online for the Florida Laws and Rules exam.

Total Fees:	
NPTE & Laws and Rules Exam	$100.00
NPTE Exam	$100.00
Florida Laws and Rules Exam	No Fee

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 Female

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

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.

This information is exempt from public records disclosure.

2. SOCIAL SECURITY 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: _____

3. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), F.S.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 893, F.S. (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction? Yes No

If you responded "No" to the question above, skip to question 2.

   a. If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? Yes No

   b. If "Yes" to 1, for the felonies of the third degree, has it been more than ten years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), F.S.)? Yes No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation?
      Yes No

   d. If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed (if "Yes," please provide supporting documentation)?
      Yes No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? Yes No

If you responded "No" to the question above, skip to question 3.

   a. If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? Yes No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, F.S.?
   Yes No

If you responded "No" to the question above, skip to question 4.

   a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? Yes No

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 to the address listed on the first page of the application.

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

Note: Section 456.013(1), F.S., requires that licensure applicants must supplement the original licensure application form, if there is a material change in any circumstance or condition stated therein, prior to the final granting of a license.

Since the submission of your initial application for physical therapist licensure, has there been any material change in any circumstance or condition stated therein, which might affect the decision of the board? Yes No

If you answer "Yes" to this question, explain on a separate sheet providing accurate details and submit copies of supporting documentation. Note that a "Yes" answer is not automatic cause for denial.

Name: _____

4. 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 licensed registered or certified physical therapist and physical therapy assistants. 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

The Candidate Information Booklet for the Physical Therapy Laws and Rules Computer Based Testing Examination may be obtained on our website at: https://floridasphysicaltherapy.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.