SUBMIT TO:
Department of Health
Board of Physical Therapy Practice
4052 Bald Cypress Way Bin C-05
Tallahassee, FL 32399-3255

Physical Therapist Dry Needling Attestation

1. License Holder Information

Physical Therapist Name:

____

Mailing Address:

____
Street City State ZIP

County: ______________________________

Practice Location:

____
Street City State ZIP

County: ______________________________

License Number: __________________________

2. Attestation

I have carefully read the minimum qualifications and standards of practice that are set forth in ss. 486.021, 486.025, 486.117, F.S., and rule 64B17-6.008, F.A.C., for a licensed physical therapist performing dry needling in the state of Florida, and I attest that I have successfully completed each requirement. I understand that I am to retain evidence of my qualifications and to produce that evidence if it is requested by the Board of Physical Therapy Practice or the Department of Health.

Signature: ____
Physical Therapist /Licensee Submitting Report

Date signed: _____________________

DH5057-MQA, 08/2020, Rule 64B17-6.008, F.A.C., Physical Therapist Dry Needling Attestation