



BOARD OF PHYSICAL THERAPY PRACTICE

Re-Exam Application

November 2015 Edition

Board of Physical Therapy Practice

Mission: To protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts.

4052 Bald Cypress Way, Bin # C05
Tallahassee, Florida 32399-3255
Phone: (850) 245-4373 Fax: (954) 358-4424
Website: www.FloridasPhysicalTherapy.gov

Retake Applicant:

An applicant who fails the NPTE and/or Florida laws and rules examinations must submit a **Retake Application** and the application fees to the Board of Physical Therapy Practice in order to schedule a retake examination. If you applied for Special Testing Accommodations, you will be required to submit additional applications for Special Testing Accommodations. In addition to re-applying to the Board of Physical Therapy Practice, applicants must re-register Online to FSBPT and pay the FSBPT fees to be scheduled to re-take the NPTE and/or laws and rules exam.

NPTE – Third Exam Failure:

Any applicant who applies through Florida and **has failed the NPTE exam three times in any jurisdiction must complete a remedial training** as outlined in 64B17-3.002 and 64B17-4.002, F.A.C., approved by the Board **prior** to seating for the NPTE examination two more times. The remedial training must be taken after the third attempt.

NOTE: The FSBPT has a 3-attempt limit within a 12-month period in retaking the NPTE exam.

Important Note: If you have taken and failed the exam in any jurisdiction more than five attempts, you are not eligible to be licensed in Florida.

Special Testing Accommodations: *(Forms must be completed and submitted at the time of application)*

Special testing accommodations may be requested by submitting the following:

- Application for candidates requesting special testing accommodations in accordance with the American's with Disabilities Act
- Application for special testing accommodations due to a religious conflict

Persons/Applicants who have previously received special testing accommodations in accordance with the American's with Disabilities Act may submit the following:

- Re-application for candidates requesting special testing accommodations in accordance with the American's with Disabilities Act

The application must be submitted no later than sixty (60) days prior to sitting for the examination. Please contact the Bureau of Operations immediately for an application at (850) 245-4252 or download the application directly from our website: <http://floridasphysicaltherapy.gov/resources/> under Forms & Requests.



Board of Physical Therapy Practice

Mailing address for application & fees:

P.O. Box 6330
Tallahassee, FL 32314-6330
Phone: (850) 245-4373 ~ Fax (954) 358-4424
Website: www.flhealthsource.com

(CLIENT 5501/PT)
(CLIENT 5502/PTA)

1. RE-EXAM APPLICATION TYPE, FEES and METHODS (Please Type or Print Legibly In Blue or Black Ink) – (Money order or check, certified or cashier check preferred, payable to: The Dept. of Health)

Check which exam(s) you are re-taking:

- NPTE & Laws and Rules Exam – Total fee = \$100
- NPTE Exam – Total fee = \$100
- Florida Laws and Rules Exam – No Fee

Physical Therapist (Client 5501) OR Physical Therapist Assistant (Client 5502)

- I have registered Online to FSBPT Website at <https://www.fsbpt.net/pt> for the NPTE.
- I have registered Online to FSBPT Website at <https://www.fsbpt.net/pt> for the Florida laws and rules exam.

(It is suggested that you register online to FSBPT website <https://www.fsbpt.net/pt>. A delay in this step may delay your process.)

2. PROFILE INFORMATION (List your full, legal name as it should appear on license, no nicknames or shortened versions.)

NAME: Last _____ First _____ Middle _____

List all names by which you are currently known or have been known in the past. _____

MAILING ADDRESS _____

IMPORTANT: Postal Service does not forward Government mail. You must keep address updated during licensure process to avoid delay. **If you use a P.O. Box address as mailing address we must also have a physical address.**

Apt. No. _____ City _____ State _____ Zip _____ Country _____

PRACTICE ADDRESS (If not applicable indicate with N/A)

Apt. No. _____ City _____ State _____ Zip _____ Country _____

Mailing address will display on the Internet if you have not provided a practice location address.

DATE OF BIRTH (m/d/yr)

WORK NUMBER: _____

HOME NUMBER: _____

CELL NUMBER: _____

FAX NUMBER: _____

CORRESPONDENCE VIA E-MAIL? YES NO

E-MAIL ADDRESS: _____@_____

Please print legibly. By checking "yes", you agree to allow the board office to contact you with information regarding your application via e-mail. Under Florida law, e-mail addresses are public. Please print legibly. By checking "yes", you agree to allow the board office to contact you with information regarding your application via e-mail. Under Florida law, e-mail addresses are public records. If you do not want your e-mail address released in response to a public records request, do not send electronic mail to this entity. Instead, contact this office by phone or in writing.

3. Please indicate date(s) of previous NPTE examinations: _____

Section 486.051 and 486.104, Florida Statutes, An applicant who has failed to pass the national physical therapy examination by or on the fifth attempt, regardless of the jurisdiction through which the examination was taken, is precluded from licensure in Florida.

4. EQUAL OPPORTUNITY DATA

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 60-3, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR38295 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: Male Female

Are you a US citizen? YES NO If NO, give alien number: _____

ETHNIC ORIGIN: White Black Asian/Pacific Hispanic Other

HISTORY PURSUANT TO SECTION 456.0635(2) F.S.

IMPORTANT NOTICE: Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer YES to any of the following questions, please provide 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 below. Supporting documentation includes court dispositions or agency orders where applicable.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? <i>(If you responded "no", skip to #2.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. If "yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. If "yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?	<input type="checkbox"/> Yes <input type="checkbox"/> 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).	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? <i>(If you responded "no", skip to #3.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? <i>(If "No", do not answer 3a. and skip to #4.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? <i>(If "No", do not answer 4a or 4b. and skip to #5.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Have you been in good standing with a state Medicaid program for the most recent five years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Did the termination occur at least 20 years before the date of this application?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. If "yes" to any of the questions 1 through 5 above, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession's licensing board or the Department of Health? <i>(If "yes", please provide official documentation verifying your enrollment status.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No

HISTORY PURSUANT TO SECTION 456.013(1), F.S.

Note: Section 456.013(1), Florida Statutes, 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. If you answer "yes" to this question, explain on a separate sheet providing accurate details and submit copies of supporting documentation. Please note that your "yes" answer would not be an automatic cause for denial.

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

Name:

Social Security Number:

Last	First	Middle	

The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.

SPECIAL TESTING ACCOMMODATION:

Are you applying for special testing?

Yes ____ **NO** ____

If yes, please see application instructions.

*** This page is exempt from public records disclosure.**