Final Order / Continuing Education Credit Florida Laws and Rules Application

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

Final Order / Continuing Education Credit
Florida Laws and Rules Application

Board of Physical Therapy
4052 Bald Cypress Way, Bin C-05
Tallahassee, FL 32399-3255
Fax: (850) 245-4373
Email: info@floridasphysicaltherapy.gov

This application is only for use by current license holders and should only be used to fulfill a Final Order requirement or to apply for continuing education credit.

Choose the appropriate license type:

☐ **Physical Therapist** (5501) License #: _____

☐ **Physical Therapist Assistant** (5502) License #: _____

Choose the reason for application:

☐ **Fulfill Final Order** Case #: _____

☐ **Continuing Education Credit**

☐ **I have registered online with the FSBPT (https://www.fsbpt.org) for the Florida laws and rules exam**

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 CFR 41 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.

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3. SPECIAL TESTING ACCOMMODATIONS

Applicants must have a qualifying medical condition in order to receive special 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/application-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

4. APPLICANT BACKGROUND

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

_____

5. 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?

_____

Name: _____

6. 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. 486.107, 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 Division 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/fsbpt for fee and payment information.