Application for Physical Therapist Licensure by Endorsement of Foreign Examination

Board of Physical Therapy
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: www.floridasphysicaltherapy.gov
Email: MQA.PhysicalTherapy@flhealth.gov
Phone: (850) 245-4373
FAX: (850) 414-6860

DH-MQA 5104, 8/2024, 64B17-3.001, F.A.C.

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.

DH-MQA 5104, 8/2024, Rule 64B17-3.001, F.A.C.

Florida Laws and Rules Examination

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

The examination fee must be paid directly to the FSBPT. Visit www.fsbpt.org for examination 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.

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

Physical Therapist (1017) **$180.00**

☐ **I have registered with the FSBPT (https://www.fsbpt.org) for the Florida Laws and Rules examination.**

Total fee of $180.00 includes the following:	
Application Fee	$100.00
Licensure Fee	$75.00
Unlicensed Activity Fee	$5.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. An applicant who is denied licensure or withdraws their application is entitled to a $80.00 (Initial Licensure Fee, Student Loan Forgiveness Fund, and Unlicensed Activity Fee) refund. Fees are refundable for up to three years from the date of receipt.

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

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

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.

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 Statutes, authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

U.S. Social Security Number: _____

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, Florida Statutes. 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 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/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

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 license in the state of Florida? ☐ Yes ☐ No

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

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

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.

☐ **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. AVAILABILITY FOR 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

If you respond "Yes," your name will be added to a listing that is available to the Department of Health if a disaster is declared. If you live in an area where you may be able to help you will be called on if needed.

Name: _____

6. EDUCATION HISTORY

A. List in chronological order schools, 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 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.

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

7. EXAMINATION HISTORY

Have you passed an examination in physical therapy administered by an authorized examining board in a country outside the United States? ☐ Yes ☐ No

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.

9. DISCIPLINE HISTORY

A. Have you ever had a health care license to practice any profession revoked, suspended, or otherwise acted against, including denial of licensure, in 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

*For the questions below, you **must include** all misdemeanors and felonies, even if adjudication was withheld. Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are **not** minor traffic offenses for purposes of this question.*

*Pursuant to s. 943.0585(6)(b), Florida Statutes, and s. 943.059(6)(b), Florida Statutes, an applicant seeking to be licensed by the Department of Health **must disclose** expunged and sealed criminal history records.*

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? ☐ 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.

11. 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), Florida Statutes.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under ch. 409, Florida Statutes (relating to social and economic assistance), ch. 817, Florida Statutes (relating to fraudulent practices), ch. 893, Florida Statutes (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 10 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), Florida Statutes)? ☐ Yes ☐ No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), Florida Statutes, 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," provide supporting documentation)? ☐ Yes ☐ No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to 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)? ☐ 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, Florida Statutes? ☐ 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

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

12. 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), Florida Statutes. 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, Florida Statutes, or that I possess licensure in another state, the district of Columbia, or a territory as required by s. 486.107, Florida Statutes, is true.

I hereby acknowledge that practice as a physical therapist in Florida is governed by ch. 456 and 486, Florida Statutes, and Rule chapter 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), Florida Statutes, 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 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://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.

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.