APPLICATION FOR APPROVAL OF CONTINUING PHYSICAL THERAPY EDUCATION
INIDIVIDUAL LICENSEE

Florida Physical Therapy Association
Continuing Education Department
800 N Calhoun St #1A, Tallahassee, FL 32303
850-222-1243 * FAX: 850/224-5281
www.fpta.org

FOR OFFICE USE ONLY:

FPTA Accreditation Number: _____
Decision by FPTA:
_____Approved ____Partial Approval ____Denied

CEHS Approved: _____ Live_____

Date Approved: _____ HS_____

Date licensee notified: _____

Decision by: _____
CE Broker Published Tracking # 10- _____

Approved for Calendar Year: _____
Approved for Licensure period: _____

PLEASE TYPE INFORMATION OR PRINT LEGIBLY. INABILITY TO READ DOCUMENT MAY RESULT IN REJECTION OF APPLICATION. ONLY ONE COURSE CAN BE SUBMITTED PER INDIVIDUAL APPLICATION.

Applications submitted by individual licensees, PTs or PTAs, for attendance at a non pre-approved continuing education program must be received prior to the course dates or within (60) days of course completion or a late fee will be incurred. Submission for approval of a non pre-approved course does not guarantee approval, but does not diminish the value of individual choice. Approval may take 6 – 8 weeks or more. It is recommended that licensees do not wait until the end of the licensing period to apply for approval.

Attachments to application - required:

- **Course brochure and or schedule**, **CV or resume of speaker**(s) clearly indicating credentials in area of course content and license numbers (Please note that bios included in brochures or advertising are not sufficient), copy of **certificate of completion**, **program outline** that must fully describe the time devoted to each topic area, including program objectives. One CEH = 50 minutes .5 CEH = 25 minutes
    - CEU conversion: 1 CEU = 10 CEH hours
- Note: Breaks and scheduled meal times are not included in CEH calculations.
- **Check or money order** made payable to: FPTA if credit card information not provided

Date of Submission: _____ **Date(s) of Course:** _____

NAME OF COURSE:
_____

Individual Applicant: Name: LAST:_____ **FIRST:** _____

FL Lic #_____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: Home: _____ **Cell:** _____

Email: _____

Process Fee: Fee must be received with application in the form of current and valid credit card information (MC, VISA, American Express, Discover) check, or money order, made payable to: Florida Physical Therapy Association.

Individual licensee seeking individual approval fees:

☐ **$20.00 (If submitted prior to the course dates or within sixty (60) days after attendance at the program). This fee is non-refundable whether or not the course is approved. If all information is not provided there may be additional fees.**

☐ **$100.00 * (If submitted later than sixty (60) days after attendance at the program). If all information is not provided there may be additional fees.**

***If the course is not approved, the fee less $50.00 is refundable.**

☐ **Please check here if paying by credit card (see attached form)**

Course Provider(Organization if applicable) Information: Name:

Phone: **Fax:** **Email:** **Web Site:**

Address: **City:** **State:** **Zip:**

Location where course taken:
Site name:

Address:

5. Presentation Format: Please check:

- ☐ **Live presentation: such as Lecture; Interactive; Classroom**
- ☐ **Homestudy-non interactive: Audio;Video;Internet(Online e.g. WebCT, Tegrity), DVD, CD, hard copy workbooks/assigned readings**
- ☐ **Real Time Interactive Distance: Teleconference; Satellite, Webinar, Videoconference, Digital Conferencing**
- ☐ **Conference**
- ☐ **Other: please describe** _____

Indicate Type of Professional Education of course instructor(s), not moderators or sponsors, that taught course:

- ☐ **Physical therapist**
- ☐ **Allopathic physician**
- ☐ **Osteopathic physician**
- **Psychologist - licensed**
- ☐ **Physical therapist assistant**
- ☐ **Dentist**
- ☐ **Dietician - registered**
- ☐ **Educator with terminal degree**
- ☐ **Licensed social worker**
- ☐ **Massage therapist - licensed**
- ☐ **RN/NP/Nurse Specialist**
- ☐ **Exercise physiologist**
- ☐ **Homeopath – licensed**
- ☐ **Naturopath – licensed**
- ☐ **Nutritionist – certified**
- ☐ **Pharmacist – licensed**
- ☐ **Physician Assistant**
- ☐ **Acupuncture physician**
- ☐ **Athletic Trainer Certified**
- ☐ **Occupational Therapist Registered**
- ☐ **Religious leader: licensed/trained/ recognized by state**
- ☐ **Chiropractor**

☐ **Other: e.g. Complementary or alternative practitioner: please describe:**

- ☐ **Clinical Practice:**
  - ☐ **Neuro**
  - ☐ **Ortho; musculoskel**
  - ☐ **Medical**
  - ☐ **Cardiopulmonary**
  - ☐ **Integ/wounds**
  - ☐ **Peds**
  - ☐ **Geriatrics**
- ☐ **Clinical Research**
- ☐ **Evidenced Based Practice**
- ☐ **Professional Ethics**
- ☐ **Practice Management/ Administration**
- ☐ **Basic Sciences**
- ☐ **Medical Sciences**
- ☐ **Florida Law re: PT**
- ☐ **Medical Errors**
- ☐ **HIV/AIDS**
- ☐ **OSHA Guidelines**
- ☐ **Domestic Violence**
- ☐ **Documentation**
- ☐ **Medicare/Federal Law**
- ☐ **Clinical Education**
- ☐ **Alternative/ Eastern Practice Describe:**
- ☐ **Complementary/Eastern Practice Describe:**
- ☐ **Other: Describe:**

☐ **Risk Management**		

Content Relevance to PT Practice Continued: For each segment of the course, describe its relevance to physical therapy. Addenda may be attached.

Acknowledgment of Individual Florida PT/PTA Licensee Seeking Approval:
The information provided in this application is true and complete to my knowledge. I understand that submission for application for approval does not guarantee approval, and that it may take 6 – 8 weeks or longer to receive written and or electronic confirmation of the final decision.

Name of Person Submitting Application for Approval (Please Print): _____

Signature of Applicant: _____

Date: _____ FL License # _____

_____ TOTAL CONTINUING EDUCATION CONTACT HOURS REQUESTED

For Office Use Only:

Total CEHs in the following areas of certification:

___Clinical Practice	**___Practice Management/ Administration**	**___Medical Errors**	**___Risk Management**
___Clinical Research	**___Basic Sciences**	**___HIV/AIDS**	**___Documentation**
___Evidenced Based Practice	**___Medical Sciences**	**___OSHA Guidelines**	**___Medicare/Federal Law**
___Professional Ethics	**___Florida Law re: PT**	**___Domestic Violence**	**___Other: Describe:**
		___Clinical Education	

_____TOTAL CONTINUING EDUCATION CONTACT HOURS APPROVED

Notes/Comments:

Credit Card Authorization Form

Please complete and fax back to **FPTA at 850.224.5281** or mail with your application**.**

Name: _____

Date: _____ **Amount to be Charged:** _____

Reason for Charge: _____

_____

Credit Card Information (We accept MasterCard/Visa, Discover and American Express)

Cardholder Name: _____

Card Billing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Corporate Cards: Provide address where the credit card statements are received.

Credit Card Number: _____

Expiration Date: _____ **Security Code:** _____

I hereby authorize **Florida Physical Therapy Association** to process payment for the above services by method of the charge card information given.

Card Holder Signature: _____ **Date:** _____

Florida Physical Therapy Association Group Federal Tax ID: 59-6135438

Note: *Your card will be charged upon receipt, unless otherwise noted. This form must accompany any order in which you would like to use a credit card. Once your credit card has been charged, this information will NOT be retained in our office.*

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