APPLICATION FOR APPROVAL OF CONTINUING PHYSICAL THERAPY EDUCATION
INDIVIDUAL LICENSEE

Florida Physical Therapy Association
Continuing Education Department
2104 Delta Way Suite 7, 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: _____ Certificate_____

Date Approved: _____ Home study_____

Date licensee notified: _____ Live_____

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

Approved for Calendar Year: _____

PLEASE TYPE INFORMATION OF 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 after the course was completed, 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

Licensure Period Requested for: _____ **Calendar Year Requested for:** _____

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**

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

Content Relevance to PT Practice: Please indicate the general category of the overall course content.

☐ Clinical Practice: ☐ Neuro ☐ Ortho; musculoskel ☐ Medical ☐ Cardiopulmonary ☐ Integ/wounds Peds ☐ Geriatrics ☐ Clinical Research ☐ Evidenced Based Practice ☐ Professional Ethics ☐ Risk Management	☐ 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:

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 # _____

For Office Use Only:

Total CEHs in the following areas of certification:

___Clinical Practice ___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 ___Clinical Education	___Risk Management ___Documentation ___Medicare/Federal Law ___Other: Describe:

_____ TOTAL CONTINUING EDUCATION CONTACT HOURS REQUESTED

_____TOTAL CONTINUING EDUCATION CONTACT HOURS APPROVED

_____SENT TO COMMITTEE FOR REVIEW _____NO ___YES

Notes/Comments:

Florida Physical Therapy Association

2104 Delta Way Unit #7, Tallahassee, FL 32303 · phone 850/222-1243 · fax 850/224/5281

Credit Card Authorization Form

Date:_____

Name: _____

Amount to be Charged:_____

Reason for Charge:_____

Note: Card will be charged upon receipt, unless otherwise noted.

Cardholder Name:_____

Credit Card Holder Billing Address: _____

City_____ State: _____ Zip Code: _____

Corporate Card Holders: Please provide your company's address where the credit card statements are received
We accept MasterCard/Visa, Discover and American Express

Credit Card Number: _____

Expiration Date: _____

Security Code:_____

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

Card Holder Signature: _____ Date: _____

Please complete and Fax back to **FPTA at 850/224-5281** or mail with your application**.**

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