Request for Verification of PT License/Registration

FOR APPLICANT TO COMPLETE BEFORE SUBMITTING TO INSTITUTION

Instructions for applicant: Please complete this section and send to the appropriate regulatory authority that will verify your license to practice physical therapy. Along with this form, include an envelope addressed to FACTS, 1930 Winter Street, Kingsburg, CA 93631

LAST NAME	FIRST NAME	MIDDLE NAME

DATE OF BIRTH (MM/DD/YY)	FILE NUMBER

LICENSING AUTHORITY: _____

NAME UNDER WHICH LICENSE WAS ISSUED (if different from that above):

_____

LAST FIRST MIDDLE

LICENSE NUMBER: _____

MARK THIS BOX IF YOU DO NOT HOLD A LICENSE, AND RETURN COMPLETED FORM TO FACTS: ☐

HOME PHONE: _____ WORK PHONE: _____

Email: _____

I hereby authorize the verification of my licensure or other record indicating my eligibility to practice physical therapy in your jurisdiction to Foreign Academic Credentialing Tools and Services (FACTS).

_____

APPLICANT SIGNATURE

_____

DATE

FOR INSTITUTION TO COMPLETE BEFORE SUBMITTING TO FACTS

Directions for Regulatory Authority: Please send this completed form to

FACTS
1930 Winter Street
Kingsburg, CA 93631

Name of Regulatory Authority: _____

Address of Institution: _____

STREET *CITY*

_____

STATE *ZIP CODE* *COUNTRY*

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Phone Number: _____

The individual above holds a license or is otherwise authorized to practice physical therapy by the regulatory authority named above from the dates _____ to _____.

Status of license: ☐ Active ☐ Inactive ☐ Expired ☐ Restricted

If the applicants license has been restricted in any way, please attach documentation describing the reason for restriction.

SIGNATURE AND SEAL REQUIRED FOR COMPLETION OF THIS FORM

I certify that these responses are complete and accurate to the best of my knowledge. In witness, I hereby set my hand and seal of this institution on this _____ day of _____, 20_____.

Name of official: _____

Official's signature: _____