



**Board of Physical Therapy and Occupational Therapy**

PO Box 110806, Juneau, AK 99811

Phone: (907) 465-2550

Email: [PhysicalAndOccupationalTherapy@Alaska.Gov](mailto:PhysicalAndOccupationalTherapy@Alaska.Gov)

Website: [ProfessionalLicense.Alaska.Gov/PhysicalTherapyOccupationalTherapy](http://ProfessionalLicense.Alaska.Gov/PhysicalTherapyOccupationalTherapy)

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## Foreign-Educated Physical Therapist License by Examination Application Instructions

PLEASE READ the application instructions, statutes, and regulations before completing your application. Please retain this information for future reference. **YOU MUST HOLD A TEMPORARY PERMIT OR PERMANENT LICENSE TO PRACTICE PHYSICAL THERAPY IN ALASKA.**

If you received this application other than directly from the Division or its official website, the application may be outdated or not an official version. To ensure you have the official version, please contact the Division. Faxed or emailed applications will not be accepted.

### PERMANENT LICENSE – APPLICATION PROCEDURES (12 AAC 54.040)

***The following must be received by the division before your application for Foreign-Educated Physical Therapist License by Examination can be reviewed:***

#### 1. APPLICATION

A completed application, signed and notarized (#08-4926, pages 1-5).

#### 2. FEES

Fees made payable to "State of Alaska."

Nonrefundable Application Fee: \$150.00

License Fee: \$200.00

Fingerprint Processing Fee: \$ 75.00

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Total Fees Due: \$425.00

#### 3. FINGERPRINT & BACKGROUND REPORTS

Submit Fingerprinting & Background Reports - One original 8" x 8" card (FD-258). An incorrect card will be automatically rejected. The fingerprint card submitted as part of this application should be sent directly to the Board of Physical Therapy and Occupational Therapy who will submit it to the Department of Public Safety (DPS) and the Federal Bureau of Investigations (FBI) to perform a criminal background check (AS 12.62.400).

Please note that the fingerprint card will be rejected for the following reasons (28 CFR 50.12(b)):

- Incorrect type of card,
- Incomplete personal information or signatures, or
- Improperly rolled prints

If, however, an adverse report is received you may decide to challenge the accuracy or completeness of your FBI report directly with the FBI at [www.FBI.gov](http://www.FBI.gov) (28 CFR 16.30 through 16.34). Challenges to the accuracy or completeness of your State of Alaska criminal history report may be directed to the Division of Statewide Services, Department of Public Safety at <https://dps.alaska.gov/Statewide/R-I/Background/Home>.

Challenges may be given no later than 30 days after you have been notified by the department of an adverse report.

#### 4. EVALUATION

A Credentials Evaluation Report sent directly to the division by a board approved credentials evaluation service.

#### 5. REFERENCE

Professional Reference form (#08-4926a) completed and submitted to our division by the head of the physical therapy school, instructor, physician, supervising physical therapist, or supervisor.

## **6. PRECEPTOR STATEMENT**

Preceptor Statement for Internship of Foreign-Educated Physical Therapist Form (#08-4926b or #08-4926c). Your preceptor will monitor your internship with the Performance Evaluation Tool (PET) at <https://www.fsbpt.org/Free-Resources/Regulatory-Resources/Supervised-Clinical-Practice-Evaluation-Tool>.

## **7. INTERNSHIP**

When your internship is completed, the following documents must be submitted to the board:

- A. Candidate Evaluation of Internship Form (#08-4926d)
- B. Preceptor Evaluation of Foreign-Educated Candidate Form (#08-4926e)

## **8. REGISTRATION**

Applicants must register with the Federation of State Board of Physical Therapy (FSBPT). See <https://www.fsbpt.org/Secondary-Pages/Exam-Candidates/National-Exam-NPTE/Non-US-Candidates> for more information. FSBPT will forward your exam scores to our division. You must pass the exam within one year of completion of your internship.

## **9. JURISPRUDENCE QUESTIONNAIRE**

Submit a completed Jurisprudence Questionnaire Form (#08-4883) with your application.

## **TEMPORARY PERMIT**

The Board may issue a temporary permit to practice physical therapy to an applicant who meets the criteria set out in AS 08.84.065 and 12 AAC 54.050. The temporary permit allows an applicant to practice while awaiting the next examination.

*NOTE: A temporary permit will not be issued until all documentation is received and determined complete. A temporary permit may be issued only if the applicant has not taken the National Physical Therapy Examination (NPTE).*

To receive a temporary permit, numbers 1-9 in the section above must have been received along with the additional \$65.00 temporary permit fee and Statement of Responsibility for Foreign-Educated Applicant Form (#08-4926f).

## PT Information

### APPLICATION REVIEW:

The application review process is defined by the requirements set forth in state law. The Board and its staff must comply with those laws in processing applications.

The application must be completed in full. If a question does not apply, write N/A in the space provided. Please print or type. An incomplete application or any unusual circumstances noted in the application may require additional processing time. You may want to keep a copy of your application for your records. You must sign and date the application in front of a notary public. Do not provide mailing envelopes with your requests for verification of licensure, professional reference, verification of work experience, or transcripts.

The Board conducts a thorough evaluation of education, training, employment or work history, malpractice history and any criminal or disciplinary history. We recommend you do not make commitments for loans, practice start dates, home purchases, etc., based on the expectation of licensure. The Board will not accelerate one application over others nor will it forego any elements of its screening process.

### EXAMINATION INFORMATION:

Alaska participates in the Alternate Approval Pathway (AAP) which allows exam candidates who are graduates of CAPTE-accredited programs to be approved to sit for the NPTE by the FSBPT.

An applicant who has applied for, but not yet received licensure in another state, and who has passed the national physical therapy examination in that state may have the examination score transferred to the Alaska Board and may apply for licensure by examination by submitting all required documentation and by having scores transferred to this state. Contact FSBPT at [www.fsbpt.org](http://www.fsbpt.org) to have your scores transferred electronically.

The examination is offered in Alaska in one location, Anchorage. However, once approved, applicants may sit for the examination at any Prometric Test Center in the United States.

### ACCOMMODATIONS:

If you require a special accommodation when taking the NPTE, contact FSBPT: <https://www.fsbpt.org/Secondary-Pages/Exam-Candidates/Testing-Accommodations>.

### LEGAL NAME CHANGE:

If any of the required documents (i.e., transcripts, verifications of licensure, etc.) will be issued under a former name, submit marriage license, divorce dissolution and/or court documents that are notarized as a "certified true copy of the original document."

### IMMIGRATION:

In accordance with AS 08.84.032(a)(4), the applicant must have met applicable requirements under the Federal Immigration and Nationality Act, unless a United States citizen.

### CREDENTIAL EVALUATION:

Before applying, you must have your foreign education evaluated by a credentialing provider who uses the qualifying Course Work Tool. If the review determines your education is substantially equivalent to a CAPTE accredited physical therapy program at the time of graduation you may then submit your application.

If it is determined your education is not substantially equivalent to a CAPTE accredited physical therapy program, do not submit the application. First, complete the required education and have your education re-evaluated. Once you have met the educational requirements, you may submit your application.

If an applicant has not had his/her transcripts evaluated, the following credential evaluation companies have been approved by the board for this service:

<b>International Consultants of Delaware (ICD)</b> 3600 Market Street, Suite 450 Philadelphia, PA 19104-2651 (215) 243-5858 <a href="https://www.icdeval.com">https://www.icdeval.com</a>	<b>Foreign Credentialing Commission on Physical Therapy (FCCPT)</b> 124 West Street South Alexandria, VA 22314 (703) 684-8406 <a href="http://www.fccpt.org">http://www.fccpt.org</a>	<b>International Education Research Foundation (IERF)</b> 10736 Jefferson Blvd, #532 Culver City, CA 90230 institutions@ierf.org <a href="https://www.ierf.org">https://www.ierf.org</a>
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## General Information

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### **APPLICATION PROCESSING:**

The average processing time varies by program. When the application is complete and correct, all supporting documents have been received and all fees have been paid, the license may be issued. Start the process far enough in advance to allow for processing time. Applications are reviewed in order of receipt in our office, and walk-in customers should not expect immediate review

### **LICENSE TERM:**

Licenses are issued for a two-year period and expire on June 30 of even-numbered years, regardless of the date of issuance, except licenses issued within 90 days of the expiration date which are issued to the next biennial expiration date. One renewal notice will be sent via email or mail at least 30 days before license expiration to the last known email or mailing address of record. Failure to receive a renewal notice does not relieve a licensee from the responsibility of renewing a license on time.

### **PROFESSIONAL FITNESS QUESTIONS:**

A “yes” response in the application does not mean your application will be denied. If you have responded “yes” to any professional fitness questions, submit an explanation with the charging and closing court documentation (e.g. court records, fitness letters, etc.).

### **DENIAL OF APPLICATION:**

Be aware that the denial of an application for licensure may be reported to any person, professional licensing board, federal, state, or local governmental agency, or other entity making a relevant inquiry or as may be required by law.

### **RANDOM AUDIT:**

This program requires continuing education. The division will audit a percentage of license renewals. If selected for audit, you will be sent a letter with instructions for documenting proof of meeting the continuing competency requirements as you stated on this renewal form. Licensees are randomly selected by computer and may be randomly selected as often as the computer chooses. You must save your documents for at least four years so you can respond to audits. Licensees unable to comply with the audit are subject to disciplinary license action.

### **ADDRESS OR NAME CHANGE:**

In accordance with 12 AAC 02.900, it is the applicant's responsibility to notify the division, in writing, of changes of address or name. Name and address change notification forms are available on the division's website. The address of record with the division will be used to send renewals and all other official notifications. The name appearing on the license must be your current legal name.

### **CERTIFIED TRUE COPIES:**

If any of the required documents will be issued under a former name, indicate on the application and submit marriage license and/or court documents that are notarized as a “certified true copy of the original document”. To obtain a certified true copy, you must present the notary with the original document along with the photocopy. You must write, “I certify this is a true copy of the original document” and sign your name. The notary will compare the original document with the copy and then notarize your signature.

### **SOCIAL SECURITY NUMBERS:**

AS 08.01.060 requires a U.S. Social Security Number be on file with the division before a professional license is issued. If you do not have a U.S. Social Security Number, complete the Request for Exemption from Social Security Number Requirement form located at [ProfessionalLicense.Alaska.Gov](https://www.alaska.gov/professionallicense/alaska.gov).

### **PUBLIC INFORMATION:**

Please be aware that all information on the application form will be available as a public record, unless required to be kept confidential by state or federal law.

### **ABANDONED APPLICATIONS:**

Under 12 AAC 02.910, an application is considered abandoned when 12 months have elapsed since correspondence was last received from or on behalf of the applicant. An abandoned application is denied without prejudice. At the time of abandonment, the division will send notification to the last known address of the applicant, who has 30 days to submit a written request for a refund of biennial license and other fees paid. The application fee will not be refunded. If no request for refund is received within that timeframe, no refund will be issued, and all fees will be forfeited.

### **BUSINESS LICENSES:**

The status of a professional license will directly impact the status of an associated business license. Renewal applications for business licenses are mailed separately. For more information about business licenses, (907) 465-2550 or [BusinessLicense.Alaska.Gov](https://www.alaska.gov/businesslicense/alaska.gov).

### **STALE DOCUMENTS:**

Application forms, authorizations and verifications older than 12 months from the date the document was received by the division will be considered stale; the document must be resubmitted as appropriate before the application will be considered by the division or a licensing board. Application documents include the application documents and verifications of licensure from other licensing jurisdictions. (12 AAC 02.915)

**PAYMENT OF CHILD SUPPORT:**

If the Alaska Child Support Enforcement Division has determined that you are in arrears on child support, you may be issued a nonrenewable temporary license valid for 150 days. Contact Child Support Services at (907) 269-6900 to resolve payment issues.

**STATUTES AND REGULATIONS:**

The complete set of statutes and regulations for this program are available by written request or online at the division's website: *ProfessionalLicense.Alaska.Gov*. To receive notification of all proposed regulation changes, send a request with your name, preferred contact method (mail or email), and the program you want to be updated on to the regulation specialist at the following email: *RegulationsAndPublicComment@Alaska.Gov*.



THE STATE  
of **ALASKA**

Department of Commerce, Community, and Economic Development  
Division of Corporations, Business and Professional Licensing

**PHY**

FOR DIVISION USE ONLY

**Board of Physical Therapy and Occupational Therapy**

PO Box 110806, Juneau, AK 99811

Website: [ProfessionalLicense.Alaska.Gov/PhysicalTherapyOccupationalTherapy](http://ProfessionalLicense.Alaska.Gov/PhysicalTherapyOccupationalTherapy)

**Foreign-Educated Physical Therapist License by Examination Application**

**PART I Payment of Fees**

<b>Required Fees:</b>	<input type="checkbox"/> Application, License, and Fingerprint Processing Fee (\$225 is Non-Refundable)	<b>\$425.00</b>
<b>Optional Fees:</b>	<input type="checkbox"/> Temporary Permit Fee	<b>\$ 65.00</b>

**PART II Temporary Permit**

In addition to permanent licensure, I would like to request a Temporary Permit.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>Note: You are not eligible for a temporary permit if you have failed the exam.</i>			
<b>Date of National Exam:</b>		<b>Start Date of Employment:</b>	
<b>Supervising Therapist's Full Name:</b>		<b>Supervising Therapist's Alaska License Number:</b>	

**PART III Personal Information**

<b>Full Legal Name:</b>			
<b>Provide all other names used (maiden, nicknames, aliases).</b> If any documentation will be received in a prior name, you must provide a certified true copy of the documentation showing proof of legal name change(s).			
<input type="checkbox"/> Not Applicable <input type="checkbox"/> Other Names Used: _____			
<b>Mailing Address:</b>	P.O. Box or Street	City	State Zip
<b>Contact Phone:</b>		<b>Date of Birth:</b>	
<b>EMAIL AGREEMENT:</b> By choosing to receive correspondence on any matter affecting my license or other business with the Alaska Division of Corporations, Business and Professional Licensing, I agree to maintain an accurate email address through the MY LICENSE web page. I understand that failure to check my email account or to keep the email address in good standing may result in an inability to receive crucial information, potentially resulting in my inability to obtain or maintain licensure.			
<b>Email Address:</b>		<b>Select One:</b>	<input type="checkbox"/> Send my Correspondence Electronically <input type="checkbox"/> Send my Correspondence by Mail
<b>Note: If both boxes are selected above, you will receive correspondence electronically.</b>			
<b>SOCIAL SECURITY NUMBER:</b> AS 08.01.060 requires you to provide your United States Social Security Number. It is considered confidential information and will not be publicly disclosed; it may be used to verify inter-state licensure.			
<b>Immigration Work Visa Number (if applicable):</b>			

## PART IV Education

Conferred Degree:	<input type="checkbox"/> AA	<input type="checkbox"/> BS	<input type="checkbox"/> MS	<input type="checkbox"/> DPT
Name of Physical Therapy School:				
Complete Address of School:	P.O. Box or Street	City	State	Zip
Name When Degree Awarded:			Date Degree Awarded:	
Was your doctorate degree under a transitional program?	<input type="checkbox"/> Yes		<input type="checkbox"/> No	
<i>If yes, provide the information for your first degree below.</i>				
Conferred Degree:	<input type="checkbox"/> BS	<input type="checkbox"/> MS		
Name of Physical Therapy School:				
Complete Address of School:	P.O. Box or Street	City	State	Zip
Name When Degree Awarded:			Date Degree Awarded:	

## PART V Examination

Have you taken the national physical therapy examination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<i>If no, Date Scheduled: _____</i>			
<i>If yes, list all states and dates where you took the national examination below.</i>			
State	Administered By	Date Administered	Result
			<input type="checkbox"/> Pass <input type="checkbox"/> Fail
			<input type="checkbox"/> Pass <input type="checkbox"/> Fail
			<input type="checkbox"/> Pass <input type="checkbox"/> Fail

## PART VI Alaska Employment

Have you secured employment in Alaska?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alaska Business Name:		
Physical Address:	P.O. Box or Street	City State Zip
Phone Number:		Start Date of Employment:

## PART VII Fingerprints and Background Reports

- I hereby certify I have read and understand my fingerprint card will be sent to the Department of Public Safety (DPS) with the State of Alaska, and to the Federal Bureau of Investigations (FBI) to perform a criminal history background report (AS 12.62.400). To challenge an adverse report on your criminal history background report, contact either the FBI at [www.FBI.gov](http://www.FBI.gov) or the Alaska Department of Public Safety at <https://dps.alaska.gov/Statewide/R-I/Background/Home>.

## PART VIII Alaska Law

- I hereby certify I have reviewed, understand and will abide by the statutes and regulations applicable to my profession (AS 08.84 and 12 AAC 54).

## PART IX Professional Fitness Questions

The following questions must be answered. "Yes" answers may not automatically result in license denial.

For each "yes" response to any question, you must provide an **explanation and documentation**. Use the letter of explanation form (#08-4752) appended to this application; include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. A separate letter of explanation form must be provided for each "yes" answer documented below. Documentation includes copies of court orders, charging documents, board, or license actions, etc.

The contents of licensing files are generally considered public records, unless required to be kept confidential by state or federal law.

### When in doubt, disclose and explain.

1. Have you ever been disciplined by any state board or physical therapy association concerning violation of the Physical Therapy Practice Act or unethical conduct?  Yes  No
2. Have you had a professional license denied, revoked, suspended, or otherwise restricted, conditioned, or limited or have you surrendered a professional license, been fined, placed on probation, reprimanded, disciplined, or entered into a settlement with a licensing authority in connection with a professional license you have held in any jurisdiction including Alaska and including that of any military authorities or is any such action pending?  Yes  No
3. Have you ever been denied the privilege of taking an examination before any state physical therapy board?  Yes  No
4. Have you been convicted of a crime or are you currently charged with committing a crime? For purposes of this question, "crime" includes a misdemeanor, felony, or a military offense, including, but not limited to, driving under the influence (DUI) or driving while intoxicated (DWI), driving without a license, reckless driving, or driving with a suspended or revoked license. "Convicted" includes having been found guilty by verdict of a judge or jury, having entered a plea of guilty, nolo contendere or no contest, or having been given probation, a suspended imposition of sentence, or a fine.  Yes  No
5. Have you ever been convicted of a violation of any federal or state narcotic laws?  Yes  No
6. Have you ever had any malpractice settlements or judgments paid on your behalf?  Yes  No



7. Are you currently suffering from any condition, mental or physical, that impairs your judgement or that would otherwise adversely affect your ability to practice as a physical therapist in a competent, ethical and professional manner?  Yes  No

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8. Do you use drugs or alcohol in any manner that impairs your ability to practice as a physical therapist competently and safely?  Yes  No

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"Yes" Answers

**If you answered "yes" to questions 7 or 8** in addition to your personal statement, you must submit a statement from your health care provider indicating your ability to safely practice as a physical therapist. Applications submitted without the appropriate attachments will be considered incomplete and will not be processed.

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**Notary Signature Page**

<b>Applicant Name:</b>		
<b>Alaska License Number (if known):</b>		<input type="checkbox"/> <i>Application in Process</i>

**PART X Notarized Signature**

I hereby certify I am the person herein named and subscribing to this application. I further certify I have read the complete application, and I know the full content thereof. I declare all of the information contained herein, and evidence or other documents submitted herewith are true and correct.

I understand any falsification or misrepresentation of any item or response in this application, or any attachment hereto, or falsification or misrepresentation of documents to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license, registration, certificate, or permit to practice in the state of Alaska.

I further understand it is a Class A misdemeanor under Alaska Statute 11.56.210 to falsify an application and commit the crime of unsworn falsification.

A person who makes a false statement on this application may be subject to civil and criminal penalties, including prosecution for perjury (AS 11.56.200 & AS 11.56.230).

Notary Stamp	<b>Applicant Printed Name:</b>			
	<b>Applicant Signature:</b>			
	<b>Notary Public for State of:</b>		<b>Subscribed and Sworn to Before me on this Day:</b>	
	<b>Notary Signature:</b>		<b>My Commission Expires:</b>	



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## Professional Reference

→ **Applicant:** Complete this top part and forward it to your reference. It may be returned directly to the Division in the reference's own envelope, or they may email it to the above address.

<b>Applicant Name:</b>	
<b>Applicant Signature:</b>	
<b>Reference Name:</b>	

→ **Reference:** The following information must be completed in full and sent directly to the Division by the professional reference to meet the requirements; the reference must be submitted and completed by the head of the physical therapy school, instructor, physician, or supervising physical therapist or supervisor. Forms submitted and/or completed by the applicant will not be accepted.

<b>Start Date of Association:</b> (mm/dd/yyyy)		<b>End Date of Association:</b> (mm/dd/yyyy)	
<b>Professional Relationship:</b>	<input type="checkbox"/> Instructor <input type="checkbox"/> Supervisor <input type="checkbox"/> Physician	<input type="checkbox"/> Supervising Physical Therapist <input type="checkbox"/> Head of the Physical Therapy School	
<b>Comments:</b>			

### Signature

By my signature below, I certify that I was professionally associated with the applicant and the applicant is professionally capable, reliable, of good moral character and worthy of confidence. *Please print or type legibly.*

<b>Reference Name:</b>		<b>Title:</b>	
<b>Reference Signature:</b>		<b>Date:</b>	
<b>Reference Email:</b>			
<b>Institution/Clinic Name:</b>			
<b>Institution Address:</b>			



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## Preceptorship Statement for Internship of Foreign-Educated Physical Therapist

**DO NOT** begin internship until approved by the board. Internship can be minimum 6 months - 12 months in length. 6 months work averaging not less than 35 hours per week or part-time over 12 months - either option must total 910 hours.

Preceptor to use FSBPT Performance Evaluation Tool (PET) to track internship progress. See <https://www.fsbpt.org/Free-Resources/Regulatory-Resources/Supervised-Clinical-Practice-Evaluation-Tool> for details.

➔ **Applicant:** Complete this top part and forward it to your preceptor. It may be returned directly to the Division in the preceptor's own envelope, or they may email it to the above address.

<b>Applicant Name:</b>	
<b>Applicant Signature:</b>	
<b>Preceptor Name:</b>	
<input type="checkbox"/> This is a change in preceptor for a board approved internship.	

➔ **Preceptor:** The following information must be completed in full and sent directly to the Division by the preceptor to meet the requirements. Forms submitted and/or completed by the applicant will not be accepted.

<b>Facility Name:</b>			
<b>Type of Facility:</b>			
<b>Facility Address:</b>	P.O. Box or Street	City	State Zip
<b>Phone Number:</b>			
<b>Potential Internship Start Date:</b>		<b>Estimated Internship End Date:</b>	
<b>1. List the Physical Therapists on staff in the department and number of hours worked per week.</b> (There must be at least two (2) full-time licensed Physical Therapists on staff.)			
<b>Physical Therapist Name</b>	<b>License Number</b>	<b>Number of Hours Worked Per Week</b>	
<b>Other Staff in Department:</b>			

**2. Describe the facility case load by giving the approximate number of cases for the following categories:**  
 (Preceptor is not expected to treat all types of patients.)

Category	Number of Cases
<b>Modalities</b>	
<b>Acute (Orthopedic/Neurologic)</b>	
<b>Chronic (Orthopedic/Neurologic)</b>	
<b>Pediatric (Orthopedic/Neurologic)</b>	
<b>Sterile Technique (Wounds, Burns, Frostbite, etc.)</b>	
<b>Other:</b> _____	

**3. Describe the experience expected for the foreign-educated therapist:**  
 (Therapist is not expected to treat all types of patients but must treat a variety of patients. Experience should be in any of the cases in the chart above.)

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**4. List the approximate number of patients seen per day or week and the department:**

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**5. Provide brief descriptions of other programs, services, activities at the facility:**  
 (e.g., rounds, staffing's, continuing education, etc.)

Activity	Frequency

**6. Possibilities for experience at other agencies/facilities:**

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**7. Describe how direct on-site supervision by preceptor will be provided:**  
(12 AAC 54.040(c)-(h) and 12 AAC 54.590)

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**Signature**

By my signature below, I agree to act as preceptor for this intern for a period of 6 to 12 months and for a combined total of 910 hours. At the end of a minimum of 6 months, I will provide a full report to the State Physical Therapy and Occupational Therapy Board describing performance during the internship. I understand the foreign-educated therapist applicant must be under my continuous, direct supervision for the length of the internship. I attest that I will be working full-time and I assume responsibility for the intern's experience and the safety and welfare of the patient.

<b>Preceptor Name:</b>		<b>Title:</b>	
<b>Preceptor Signature:</b>		<b>Date:</b>	



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**Preceptor Credentials Review - For Federal Government Facilities: PHS & Military**

➔ **Applicant:**

Complete this top part and forward it to your preceptor who is not licensed in the State of Alaska. It may be returned directly to the Division in the preceptor's own envelope, or they may email it to the above address.

<b>Applicant Name:</b>	
<b>Applicant Signature:</b>	

➔ **Preceptor:**

The following information must be completed in full and sent directly to the Division by the preceptor to meet the requirements. Forms submitted and/or completed by the applicant will not be accepted.

<b>Preceptor Name:</b>				
<b>Mailing Address:</b>	P.O. Box or Street	City	State	Zip
<b>Phone Number:</b>				
<b>1. Education:</b>				
School Name	Address	Start Date	End Date	Degree Awarded or Number of Hours Completed
<b>2. Professional Experience (within the past 5 years):</b>				
Employer Name	Address	Start Date	End Date	Position

<b>3. Have you ever taken the National Physical Therapy Examination (NPTE)?</b> <i>If yes, provide the following information:</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Exam Date:</b>		<b>Exam Location:</b>
<b>Administered by:</b>		
<b>4. List every state where you currently hold a license.</b>		
<b>State</b>	<b>Date Issued</b>	<b>Status</b>
<b>5. Professional Fitness Questions.</b> <i>For each "yes" response to any question, you must provide an explanation and documentation. If you answered "yes" to questions 7 or 8 in addition to your personal statement, you must submit a statement from your health care provider indicating your ability to safely practice as a physical therapist.</i> <i>The contents of licensing files are generally considered public records, unless required to be kept confidential by state or federal law.</i>		
<b>1.</b> Have you ever been disciplined by any state board or physical therapy association concerning violation of the Physical Therapy Practice Act or unethical conduct?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>2.</b> Have you had a professional license denied, revoked, suspended, or otherwise restricted, conditioned, or limited or have you surrendered a professional license, been fined, placed on probation, reprimanded, disciplined, or entered into a settlement with a licensing authority in connection with a professional license you have held in any jurisdiction including Alaska and including that of any military authorities or is any such action pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>3.</b> Have you ever been denied the privilege of taking an examination before any state physical therapy board?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>4.</b> Have you been convicted of a crime or are you currently charged with committing a crime? For purposes of this question, "crime" includes a misdemeanor, felony, or a military offense, including, but not limited to, driving under the influence (DUI) or driving while intoxicated (DWI), driving without a license, reckless driving, or driving with a suspended or revoked license. "Convicted" includes having been found guilty by verdict of a judge or jury, having entered a plea of guilty, nolo contendere or no contest, or having been given probation, a suspended imposition of sentence, or a fine.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>5.</b> Have you ever been convicted of a violation of any federal or state narcotic laws?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>6.</b> Have you ever had any malpractice settlements or judgments paid on your behalf?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>7.</b> Are you currently suffering from any condition, mental or physical, that impairs your judgement or that would otherwise adversely affect your ability to practice as a physical therapist in a competent, ethical and professional manner?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>8.</b> Do you use drugs or alcohol in any manner that impairs your ability to practice as a physical therapist competently and safely?	<input type="checkbox"/> Yes <input type="checkbox"/> No	



## Notary Signature

By my signature below, I certify that the above information is true and correct and that I will comply with the statutes and regulations set out by the Alaska Board of Physical Therapy and Occupational Therapy. I understand that any false information may result in failure to obtain approval as a preceptor.

Notary Stamp	<b>Preceptor Printed Name:</b>			
	<b>Preceptor Signature:</b>			
	<b>Notary Public for State of:</b>		<b>Subscribed and Sworn to Before me on this Day:</b>	
	<b>Notary Signature:</b>		<b>My Commission Expires:</b>	



THE STATE  
of

**ALASKA**

Department of Commerce, Community, and Economic Development  
Division of Corporations, Business and Professional Licensing

**Board of Physical Therapy and Occupational Therapy**

PO Box 110806, Juneau, AK 99811

Phone: (907) 465-2550

Email: [PhysicalAndOccupationalTherapy@Alaska.Gov](mailto:PhysicalAndOccupationalTherapy@Alaska.Gov)

Website: [ProfessionalLicense.Alaska.Gov/PhysicalTherapyOccupationalTherapy](http://ProfessionalLicense.Alaska.Gov/PhysicalTherapyOccupationalTherapy)

## Candidate Evaluation of Internship

→ **Applicant:** Complete this evaluation once your internship had ended. It may be returned directly to the Division by the candidate.

<b>Applicant Name:</b>			
<b>Facility Name:</b>			
<b>Start Date of Internship:</b>		<b>End Date of Internship:</b>	

<b>1. Describe quality and adequacy of the following items. Print additional pages as needed.</b>	
<b>Physical Setting (Facility)</b>	
<b>a. Space/Layout:</b>	
<b>b. Equipment:</b>	
<b>c. Other:</b>	
<b>Patient Exposure</b>	
<b>a. Number of Patients:</b>	
<b>b. Variety:</b>	
<b>c. Scheduling:</b>	
<b>Department of Administration</b>	
<b>a. Level of Supervision:</b>	
<b>b. Fairness of Supervision:</b>	
<b>c. Adequacy of Staffing:</b>	
<b>d. Staff Relationships:</b>	
<b>e. Standards of Treatment:</b>	

<b>2. Was your role defined/understood at the beginning and throughout the internship? Was it appropriate?</b>
<b>3. What were the positive and negative aspects of this experience?</b>
<b>4. How would you improve the experience?</b>
<b>Additional Comments:</b>

<b>Signature</b>			
By my signature below, I hereby certify that the information on this evaluation is true and correct to the best of my knowledge.			
<b>Applicant Name:</b>			
<b>Applicant Signature:</b>		<b>Date:</b>	



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## Preceptor Evaluation of Foreign-Educated Candidate

➔ **Applicant:**

Complete this top part and forward it to your preceptor once your internship has ended. It may be returned directly to the Division in the preceptor's own envelope, or they may email it to the above address.

<b>Applicant Name:</b>	
<b>Applicant Signature:</b>	
<b>Evaluation:</b>	<input type="checkbox"/> Interim <input type="checkbox"/> Final

➔ **Preceptor:**

The following information must be completed in full and sent directly to the Division by the preceptor to meet the requirements. Forms submitted and/or completed by the applicant will not be accepted.

<b>Preceptor Name:</b>			
<b>Start Date of Internship:</b>		<b>End Date of Internship:</b>	
<b>Number of Hours Worked Per Week:</b>			
<b>List duties performed by candidate during preceptorship:</b>			
<b>List types of patients evaluated and treated by the candidate:</b>			
<b>Experience with other department/agencies:</b>			

Rate and/or describe the candidate's performance in the following areas.

The rating scale is as follows: **1** - Above Average, **2** - Average, **3** - Below Average, **4** - Unacceptable, **N/A** - Not Applicable, **N/E** - No Experience.

Category	Subcategory	Rating						Description of Performance
		1	2	3	4	N/A	N/E	
Quantity of Work and Effective Use of Time								
Quality of Work	Modalities							
	Acute Orthopedics							
	Acute Neurologic							
	Chronic Orthopedics							
	Chronic Neurologic							
	Pediatric Orthopedics							
	Pediatric Neurologic							
	Sterile Technique							
	Other: _____							
Communication Skills	With Patients and Families (Verbal and Written)							
	With Staff							
	Charting							
Professionalism	Personal Presentation							
	Ability to work with staff, physicians and other departments/agencies							
	Judgement							
	Ethics							
Treatment Planning and Implementation	Scheduling							
	Goal Setting							
	Implementation and Discharge							
English Proficiency	Verbal							
	Written							

Is the Candidates first language English?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the intern/candidate ready to take the NPTE?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Comments:			
Do you feel this candidate's work is adequate for independent practice?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If no, please explain why:</i>			
Overall Rating:	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair <input type="checkbox"/> Poor
Additional Comments:			

<b>Candidate Signature</b>		(For Interim Evaluation Only)	
By my signature below, I hereby certify that the information on this evaluation is true and correct to the best of my knowledge.			
Candidate Name:			
Candidate Signature:		Date:	

<b>Preceptor Signature</b>			
By my signature below, I hereby certify that the information on this evaluation is true and correct to the best of my knowledge.			
Preceptor Name:			
Preceptor Signature:		Date:	



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## Statement of Responsibility for Foreign-Educated Examination Applicant

This form must be notarized and returned directly to the Division after a foreign educated applicant has completed the 6-month internship. It may be returned directly to the Division in the supervisor's own envelope, or they may email it to the above address.

Supervisor will assume the full responsibility of supervising this applicant at the facility below:

<b>Applicant Name:</b>				
<b>Supervisor Name:</b>				
<b>Supervisor's AK Physical Therapist License Number:</b>				
<b>Facility Name:</b>				
<b>Facility Physical Address:</b>	P.O. Box or Street	City	State	Zip
<b>Facility Mailing Address:</b>	P.O. Box or Street	City	State	Zip

### Notary Signature

This supervision will be held in compliance with the statutes and regulations set forth by the State Physical Therapy and Occupational Therapy Board. AS 08.84.065, 12 AAC 54.050, 12 AAC 54.500, 12 AAC 54.510 and 12 AAC 54.590.

I understand that the applicant's temporary permit is valid for eight months from the date of issue OR until the results of the examination for which the applicant is scheduled are published, whichever occurs first. I understand and agree that if the applicant fails to take the examination for which he/she is scheduled, the applicant's permit will lapse on the day of the scheduled examination and that he/she will not be eligible to continue practicing under the permit.

By my signature below, I certify that the above information is true and correct and that I will comply with the statutes and regulations set out by the Alaska Board of Physical Therapy and Occupational Therapy.

Notary Stamp	<b>Supervisor Printed Name:</b>			
	<b>Supervisor Signature:</b>			
	<b>Notary Public for State of:</b>		<b>Subscribed and Sworn to Before me on this Day:</b>	
	<b>Notary Signature:</b>		<b>My Commission Expires:</b>	



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## Jurisprudence Questionnaire – Physical Therapist or Physical Therapist Assistant

All applicants for licensure must complete the following questionnaire prepared by the Board of Physical Therapy and Occupational Therapy. The answers to the questions will be found by reviewing the statute and regulation booklets published online. Use the statutes and regulations to determine the correct answers.

- *Principles of Practice*
- *Physical Therapy and Occupational Therapy Statutes and Regulations AS 08.84 and 12 AAC 54*
- *Centralized Licensing Statutes AS 08.01*
- *Centralized Licensing Regulations 12 AAC 02*

**Step 1:** Select the correct answer.

**Step 2:** Cite the statute or regulation where the answer was found.

1. The Board may take the following actions singularly or in combination:

- Refuse renewal
- Revoke
- Suspend
- All of the above

→ Cite Statute AS 08.84. \_\_\_\_\_

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2. According to the Centralized Statutes 08.01.075, disciplinary powers of the Board may include:

- Impose a civil fine not to exceed \$1,000
- Impose a civil fine not to exceed \$3,000
- Impose a civil fine not to exceed \$5,000
- Impose a civil fine not to exceed \$10,000

→ Cite Centralized Statute 08.01.075. \_\_\_\_\_

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3. The Board may refuse to license an applicant, may refuse to renew the license of a person, and may suspend or revoke the license of a person who:

- has attempted to obtain a license by material misrepresentation.
- has continued to practice physical therapy after becoming unfit due to physical or mental disability.
- has failed to refer a patient to another qualified professional when the patient's condition is beyond the training or ability of the person
- uses drugs or alcohol in any manner that affects the person's ability to practice physical therapy safely.
- All of the above.

→ Cite Statute 08.84. \_\_\_\_\_



4. An individual who practices without the appropriate license (including practicing with a lapsed license) is guilty of a:

- class A misdemeanor
- class B misdemeanor
- class C misdemeanor
- felony

→ Cite Statute AS 08.84. \_\_\_\_\_

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5. A physical therapist or physical therapist assistant applicant by examination who holds a temporary permit must practice under the supervision of a licensed physical therapist.

- False
- True

→ Cite Regulation 12 AAC 54. \_\_\_\_\_

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6. A physical therapist or physical therapist assistant who has been licensed 12 months or more of the concluding licensing period shall have completed during that period \_\_\_ contact hours of continuing education.

- 16
- 20
- 24
- 28

→ Cite Regulation 12 AAC 54. \_\_\_\_\_

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7. A physical therapist may concurrently supervise a maximum of how many physical therapist assistants, physical therapy aides, foreign-educated candidates, students, permittees, or any combination thereof?

- 3
- 4
- 6
- 8

→ Cite Regulation 12 AAC 54. \_\_\_\_\_

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8. An applicant for renewal of a physical therapist or physical therapist assistant license shall document having provided physical therapy services for at least \_\_\_ hours during the concluding licensing period.

- 30
- 60
- 120
- 150

→ Cite Regulation 12 AAC 54. \_\_\_\_\_

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9. Records of continuing education must be retained from the date of completion for:

- 2 years.
- 3 years.
- 5 years.
- 7 years.

→ Cite Regulation 12 AAC 54. \_\_\_\_\_

10. It is the responsibility of the \_\_\_\_\_ to notify the Division of Corporations, Business and Professional Licensing when a name or address change occurs for a licensee.

- employer
- direct supervisor
- licensee
- All of the above.

→ Cite Regulation 12 AAC 54. \_\_\_\_\_

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11. A licensee selected for audit of continuing competency requirements shall submit substantiating documentation within \_\_\_\_\_ days after the date of notification by the Division.

- 30 days
- 60 days
- 90 days
- 120 days

→ Cite Regulation 12 AAC 54. \_\_\_\_\_

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12. Per the Alaska Board of Physical Therapy and Occupational Therapy Principles of Practice, a physical therapist and physical therapist assistant must adhere to the National Professional Core Values and Ethical Standards.

- False
- True

→ Cite Regulation 12 AAC 54. \_\_\_\_\_

---

13. For continuing education activities to meet the standards of renewal, at least one half must be recognized by:

- American Physical Therapy Association (APTA)
- Other state physical therapy associations or other physical therapy licensing boards
- Federation of State Boards of Physical Therapy (FSBPT)
- Any of the above.

→ Cite Regulation 12 AAC 54. \_\_\_\_\_

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14. Continual onsite supervision means that the physical therapist or physical therapist assistant:

- is immediately available.
- is present in the department or facility where services are being provided.
- maintains continual oversight of patient-related duties.
- All of the above.

→ Cite Regulation 12 AAC 54. \_\_\_\_\_

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15. The license or permit or a copy of the license or permit must be:

- kept in the personnel file of the licensee or permit holder.
- kept with the practicing therapist at all times.
- posted in a conspicuous location in the licensee's primary place of business.
- posted somewhere in the place of business.

→ Cite Regulation 12 AAC 54. \_\_\_\_\_

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16. A physical therapist applicant who has been issued a temporary permit prior to taking the national examination may continue to practice under that temporary permit even if the physical therapist applicant fails the test, or fails to take the examination.

- False
- True

→ Cite Statute AS 08.84. \_\_\_\_\_

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17. If the licensed physical therapist agrees to supervise a physical therapist assistant, the supervising physical therapist shall:

- fully document the supervision provided.
- include a record of all consultations provided in each patient's file.
- maintain records of supervision at the physical therapist assistant's place of employment.
- countersign the patient treatment record each time the supervising physical therapist is physically present and directly supervises the treatment of a patient by the physical therapist assistant being supervised.
- All of the above.

→ Cite Regulation 12 AAC 54. \_\_\_\_\_

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18. Documentation to verify completion of continuing competency must include a valid copy of a certificate or similar verification of satisfactory completion which must include:

- a description of the continuing competency activity and the dates of actual participation or successful completion.
- the name and internet address or physical mailing address of course provider, instructor, sponsor or other entity the department may contact, as needed, to verify attendance.
- the name of the licensee and the number of continuing competency credits awarded.
- All of the above.

→ Cite Centralized Regulation 12 AAC 02. \_\_\_\_\_

---

19. To be accepted by the Board, a continuing education course or activity must contribute directly to the professional competency of a physical therapist or physical therapist assistant AND must be directly related to the skills and knowledge required to implement the principles and methods of physical therapy.

- False
- True

→ Cite Regulation 12 AAC 54. \_\_\_\_\_

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20. A business which provides telemedicine services must register with the state telemedicine business registry.

- False
- True

→ Cite Centralized Regulation 12 AAC 02. \_\_\_\_\_

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21. The scope of authorized practice for a physical therapist or physical therapist assistant includes the practice of medicine, osteopathy, chiropractic, or other methods of healing.

- False
- True

→ Cite Statute AS 08.84. \_\_\_\_\_

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# Fingerprinting Requirements

Your fingerprints will be used to check your criminal history records with the FBI [28 CFR 50.12(b)]. Procedures for obtaining a change, correction, or updating of an FBI identification record are set forth in 28 CFR 16.34.

This license application must be accompanied by a complete fingerprint card (may be used for the Alaska Department of Public Safety (DPS) and for the FBI national check). Fingerprints submitted must be on the standard FBI Form *FD-258*. These forms can be found for purchase online or often at local law enforcement or other authorized agencies that offer fingerprinting. Take the card, the instructions, and your photo identification to local law enforcement or other authorized agency to have the fingerprinting done. Please follow these instructions and the back of the fingerprint card.

DPS/the FBI will not accept any fingerprint cards that do not comply with the following:

1. No staples or staple holes are permitted in fingerprint cards. Do not tape, tear or fold the cards.
2. Ensure the prints are done properly and well. Poor quality prints, smudging, non-rolled or incomplete fingerprints will cause the cards to be rejected by DPS, the FBI or both.
3. All applicable sections of the top portion of the card must be legible and complete. The information/signatures must be typed, printed or signed in BLACK ink; no other color is permitted. Individual information blocks on the fingerprint cards must be filled in as follows:

**NAME:** Applicant's last name (comma), first name, then middle name (if any); suffix denoting seniority (Jr., Sr., II, etc.) follow the middle or first name. *Be sure to write your name in clear handwriting. Unclear handwriting may result in misspellings on the required background report and/or may require new fingerprint cards to be submitted.*

**SIGNATURE OF PERSON FINGERPRINTED:** Must be signed by the applicant.

**RESIDENCE OF PERSON FINGERPRINTED:** Enter the applicant's physical residence address.

**DATE:** Date fingerprinting was done.

**SIGNATURE OF OFFICIAL TAKING FINGERPRINTS:** Signature of the person who rolled the fingerprints.

**EMPLOYER AND ADDRESS AND REASON FINGERPRINTED:** These blocks to be completed by the State of Alaska.

**ALIASES/AKA:** List other names used by the applicant that are different than that entered in NAME block; also, list maiden names and all previous married names of females. Enter client number at bottom of block.

**CITIZENSHIP/CTZ:** Enter US if a citizen of the United States; otherwise, enter the correct country abbreviation.

**YOUR NO./OCA:** Leave this space blank (Originating Agency Case Number).

**FBI NO./FBI:** Enter the applicant's assigned FBI number, if known.

**ARMED FORCES NO./MNU:** Leave this space blank.

**SOCIAL SECURITY NO./SOC:** List the applicant's Social Security Number.

**MISC. NO./MNU:** If Alaska resident, enter the applicant's Alaska driver's license or state ID# (if applicable).

**ORIGINATING AGENCY IDENTIFIER (ORI):** Leave blank, will be printed with AKAST0100, DPS, ANCHORAGE, AK.

**SEX:** F (Female) or M (Male). Note: Indicate if applicant is a transvestite (cross-dresser) or has had a sex change operation. List any opposite sex names used in the ALIASES/AKA block.

**RACE:** Race must be indicated by one of the following one-character alphabetic codes:

*A = Asian, Pacific Islander, Chinese, Japanese, Polynesian, Korean, Vietnamese*

*B = Black*

*I = American Indian, Alaskan Native, Eskimo*

*W = White, Mexican, Latin, Puerto Rican, Cuban, Central/South American and other Spanish cultures*

*U = Unknown*

**HEIGHT:** Must be shown in feet and inches, fractions rounded off to nearest inches (i.e., 5'11" entered as 511).

**WEIGHT:** Must be expressed in pounds, fractions rounded off to nearest pound.

**EYES:** Indicate eye color by one of the following three-character codes:

*BLK = Black*                      *GRY = Gray*                      *MAR = Maroon*

*BLU = Blue*                      *GRN = Green*                      *PNK = Pink*

*BRO = Brown*                      *HAZ = Hazel*                      *UNK = Unknown*

**HAIR:** Indicate hair color by one of the following three-character codes:

*BAL = Bald*                      *BRO = Brown*                      *SDY = Sandy*

*BLK = Black*                      *GRY = Gray*                      *WHI = White*

*BLN = Blonde*                      *RED = Red*                      *XXX = Unknown*

**PLACE OF BIRTH/POB:** List the state, territorial possession, Canadian province, or country of birth. Use the correct abbreviation for foreign countries or correctly spell the country's name. Do not use city or county names as a POB.

**DATE OF BIRTH/DOB:** Enter birth date as month, day, year. Fingerprint cards of persons 80+ years of age are not processed by the FBI. Note: If DOB is blank, the card will be immediately returned unprocessed.

**FINGERPRINT IMPRESSION BLOCKS:** (Individual and Simultaneous) It is very important care be taken to prepare the fingerprint cards properly. It will save much more time and avoid rejections to assure acceptability the first time. Use black printer's ink. Fingers should be clean and dry before being inked. Use neither too much nor too little ink, nor too much nor too little pressure to make the impressions. To help ensure legibility, all 10 fingers must be rolled from nail to nail and include the first flexion crease. Detail must be sufficient on all 10 individual prints to clearly define the loop, whorl, arch, or other pattern. Roll the prints in the correct sequence.

All instructions must be followed correctly. All information on the cards is essential. Please double check your work before sending the card. Illegible, incomplete, or incorrect cards will be rejected and returned unprocessed.

## Noncriminal Justice Applicant's Privacy Rights

As an applicant who is the subject of a national fingerprint-based criminal history record check for a noncriminal justice purpose (such as an application for employment or a license, an immigration or naturalization matter, security clearance, or adoption), you have certain rights which are discussed below:

- You must be provided written notification<sup>1</sup> that your fingerprints will be used to check the criminal history records of the FBI and the State of Alaska.
- You must be provided, and acknowledge receipt of, an adequate Privacy Act Statement when you submit your fingerprints and associate personal information. This Privacy Act Statement should explain the authority for collecting your information and how your information will be used, retained, and shared.<sup>2</sup>
- If you have a criminal history record, the officials making a determination of your suitability for the employment, license or other benefit must provide you the opportunity to complete or challenge the accuracy of the information in the record.
- The officials must advise you that the procedures for obtaining a change, correction, or update of your criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34.
- If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the officials deny you the employment, license, or other benefit based on information in the criminal history record.<sup>3</sup>

You have the right to expect that officials receiving the results of the criminal history records check will use it only for authorized purposes and will not retain or disseminate it in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.<sup>4</sup>

If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at:

<https://www.fbi.gov/services/cjis/identity-history-summary-checks>

If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI. The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30 through 16.34).

To challenge the accuracy or completeness of your State of Alaska criminal history records, go to the Division of Statewide Services, Department of Public Safety at <https://DPS.Alaska.Gov/Statewide/R-I/background/Home> to request to correct criminal justice information.

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<sup>1</sup> Written notification includes electronic notification but excludes oral notification.

<sup>2</sup> <https://www.fbi.gov/services/cjis/compact-council/privacy-act-statement>

<sup>3</sup> See 28 CFR 50.12(b) and Alaska Regulation AAC 13.68.300.

<sup>4</sup> See 5 U.S.C. 552a(b); 28 U.S.C. 534(b); 42 U.S.C. 14616, Article IV(c); 28 CFR 20.21(c), 20.33(d) and 906.2(d).

## Privacy Act Statement

*This privacy act statement is located on the back of the FD-258 Fingerprint Card.*

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

As of 03/30/2018



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## Letter of Explanation for a Professional Fitness “Yes” Answer

Use this form only to explain and document any professional fitness “yes” answers. A “yes” answer is not necessarily disqualifying but concealing one may be.

Each “yes” answer requires a separate explanation and associated documentation. Submit all relevant documentation with this form, even if you have previously provided it.

- **Explanations** include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. If the space provided is insufficient, make additional copies as needed.
- **Documentation** includes copies of court orders, charging documents, board or license actions, decisions against your professional certification, satisfaction of consent agreements (fines paid, community service completed, off probation, etc.), and fitness to practice letters (statement from your provider that you are safe to practice if you check “yes” to any of the questions regarding mental or physical health, or drug or alcohol abuse or addiction).
- **Disciplinary actions** may include, but not be limited to, suspension, surrender, revocation, probation, academic probation, reprimand, censure, restricted license, limited license, conditioned license, or letters of counseling, concern, advice, warning, caution, admonishment, or reprimand.

If you have multiple “yes” answers or multiple incidents for any professional fitness question, you must use a separate copy of this form and provide a full explanation and documentation for each incident.

The contents of licensing files are generally considered public records, unless required to be kept confidential by state or federal law.



Write the professional fitness question number you are answering “yes” to in the box.

<b>Location of Incident:</b>		<b>Date of Incident:</b>	
<b>Explanation of Incident:</b> When in doubt, disclose and explain. <i>Make copies as necessary.</i>			

**Did you attach all applicable documents associated with this incident?**

- Court Orders     
  Consent Agreements     
  Disciplinary Actions     
  Charging Documents  
 Court Records     
  Fitness to Practice     
  All Other Documentation Related to This Incident  
 I have additional incidents for this “yes” answer, or “yes” answers to other Professional Fitness questions and have attached a separate copy of this form for each incident.

<b>Full Name:</b>		<b>Program:</b>	
<b>Signature:</b>		<b>Date Signed:</b>	



THE STATE  
of **ALASKA**

Department of Commerce, Community, and Economic Development  
Division of Corporations, Business and Professional Licensing

FOR DIVISION USE ONLY

State of Alaska  
PO Box 110806, Juneau, AK 99811  
Phone: (907) 465-2550

## Credit Card Payment Form

All major credit cards are accepted. For security purposes, do not email credit card information. Include this credit card payment form with your application.

Name of Applicant or Licensee:			
Profession Type (e.g., Acupuncture):		License Number (if applicable):	
I wish to make payment by credit card for the following (check all that apply):			AMOUNT
<input type="checkbox"/>	Application Fee:		
<input type="checkbox"/>	License or Renewal Fee:		
<input type="checkbox"/>	Other (fine, exam, etc.):		
1.			
2.			
			TOTAL:

Name (as shown on credit card):			
Mailing Address:			
Phone Number:		Email (Optional):	
Signature of Credit Card Holder:			

**CREDIT CARD INFO: Your payment cannot be processed unless all fields are completed.**

1. Credit Card Number:		<p><b>All 3 fields MUST be completed.</b></p> <p>This section will be destroyed after the payment is processed.</p>
2. Expiration Date:		
3. Security Code:		