



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**

State Office Building, 333 Willoughby Avenue, 9<sup>th</sup> Floor

PO Box 110806, Juneau, AK 99811-0806

Phone: (907) 465-2580 ★ Fax: (907) 465-2974

Email: [license@alaska.gov](mailto:license@alaska.gov)

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

**FOREIGN-TRAINED PHYSICAL THERAPIST AND PHYSICAL THERAPY ASSISTANT  
LICENSE APPLICATION PACKET**

A person who does not hold their first professional degree from a qualifying U.S. educational institution may apply for licensure as a foreign-trained physical therapist or physical therapy assistant in the State of Alaska under the provisions of AS 08.84. Applicants may qualify for licensure by credentials (see Part I) or by examination (see Part III). Parts II and IV explain the qualifications for issuance of a temporary permit.

If you have questions concerning the licensing requirements described, please contact the licensing examiner for the State Physical Therapy and Occupational Therapy Board via email at: [license@alaska.gov](mailto:license@alaska.gov).

**Please read the application and instructions carefully. Failure to do so may cause additional correspondence and delay the processing of your application. All required forms and documentation must be mailed to the Division directly from the required source or they will not be accepted. To avoid delays, do not provide a mailing envelope to the other agencies or sources that are required to mail documents directly to the Division.**

**IMMIGRATION**

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

**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you received this application other than directly from the Division or its official website, the application may be outdated or not an official version.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, download the application from our website, [ProfessionalLicense.Alaska.Gov/PhysicalTherapyOccupationalTherapy](http://ProfessionalLicense.Alaska.Gov/PhysicalTherapyOccupationalTherapy), or contact the Division.**

**CREDENTIAL EVALUATION**

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

|   |  |  |
|---|--|--|
| <p>FOREIGN CREDENTIALING<br/>COMMISSION ON PHYSICAL<br/>THERAPY (FCCPT)<br/>124 West Street South<br/>Alexandria, VA 22314<br/>(703) 684-8406<br/><a href="http://www.fccpt.org">http://www.fccpt.org</a></p> | <p>INTERNATIONAL CONSULTANTS<br/>OF DELAWARE (ICD)<br/>PO Box 8629<br/>Philadelphia, PA 19101-8629</p> | <p>INTERNATIONAL EDUCATION<br/>RESEARCH FOUNDATION (IERF)<br/>PO Box 3665<br/>Culver City, CA 90231-3665</p> |
|---|--|--|

If you use a company other than above, the board will review the evaluation on a case-by-case basis.

If an applicant cannot submit a transcript for evaluation as required, the board will, in its discretion, accept as evidence of education

- (1) verification from the licensing authority in another state that has evaluated the applicant's education; or
- (2) verification from an American educational institution or professional association that
  - (A) previously required documentary evidence of the applicant's education; or
  - (B) directly verified the applicant's education that has been evaluated.

A foreign-trained therapist must pass the Test of English as a Foreign Language (TOEFL); Test of Written English (TWE), and Test of Spoken English (TSE) OR the internet-based test (TOEFL-IBT) administered by the Educational Testing Services, P.O. Box 6151, Princeton, NJ 08541, Telephone (609) 771-7100. Refer to 12 AAC 54.040(j). **EVEN IF ENGLISH IS YOUR PRIMARY LANGUAGE OR YOUR ONLY LANGUAGE, YOU ARE REQUIRED BY LAW TO PASS THE TOEFL.**

English language proficiency passing scores according to 12 AAC 54.040(j):

Test of English as a Foreign Language (TOEFL) 560 points written examination or 220 points computerized examination;  
 Test of Written English (TWE) – 4.50 points  
 Test of Spoken English (TSE) – 50 points

**OR**

Test of English as a Foreign Language Internet-Based Test (TOEFL – IBT)

Writing – 24 points  
 Speaking – 26 points  
 Reading Comprehension – 21 points  
 Listening Comprehension – 18 points

**PART I – LICENSURE BY CREDENTIALS**

The following documents must be in this office before the board will consider your application for licensure by credentials. Make check or money order payable to the State of Alaska.

1. A completed notarized application (form 08-4091) and \$150.00 nonrefundable application fee.
2. Initial licensure fee of \$240.00 for Physical Therapist or \$175.00 for Physical Therapy Assistant.
3. Authorization of Release of Records (form 08-4091a)
4. Jurisprudence Questionnaire (form 08-4091b).
5. A Credentials Evaluation Report sent directly by the credentials evaluation service, or if you graduated from a School of Physical Therapy approved by the “Council on Medical Education and Hospitals of the American Medical Association,” or the “American Physical Therapy Association,” you only need to have your School of Physical Therapy submit certified transcripts (sent directly from school).
6. A report of your scores obtained in a national physical therapy examination. You must have received a passing score in accordance with regulation 12 AAC 54.080(a). Contact FSBPT at their website [www.fsbpt.org](http://www.fsbpt.org) to have your scores transferred electronically.
7. Verification of Licensure form completed by the state(s) or countries where you hold or have ever held a license or permit to practice physical therapy. You must have a current license in good standing in a U.S. state, territory or the District of Columbia (form 08-4091f).
8. Supervised Work Experience Verification form must be completed by a supervising physical therapist showing satisfactory evidence of a minimum of six months supervised work experience while licensed in another state, territory, or the District of Columbia; or satisfactory completion of an internship program as described under Part IV of this application (form 08-4091e).
9. Verification of successful passage of all sections in one testing session of the English language proficiency examination sent directly from the Educational Testing Services.
10. Professional Reference form (form 08-4091c) completed by the head of the physical therapy school, instructor, physician, or physical therapist other than the physical therapist preceptor described in 12 AAC 54.040(e)-(f).
11. Verification of one of the following and mailed directly to the Division from the source:
  - a. at least 60 hours of physical therapy employment within the 24 months immediately preceding the date the application is received by the department (form 08-4091d);
  - b. passage of the national examination within the 24 months immediately preceding the date the application is received by the Division (verification of exam scores must come directly from the examination agency, FSBPT);

**PART II – TEMPORARY PERMIT FOR  
 FOREIGN-TRAINED CREDENTIAL APPLICANTS**

The board will issue a temporary permit to practice physical therapy to an applicant who meets the criteria set out in AS 08.84.065. Do not apply for a temporary permit if you answer “Yes” to any of the professional fitness questions on page four of the application (form 08-4091). The temporary permit allows an applicant to practice while waiting to complete application for licensure by credentials. All documents under Part I above, plus the \$65.00 temporary permit fee, must be in this office before your application for a temporary permit will be considered.

## PART III – LICENSURE BY EXAMINATION

Alaska offers the national physical therapy examination by computer through the Federation of State Boards of Physical Therapy. The board must approve your application to sit for the examination. The exam is offered in Alaska in one location, Anchorage. However, once approved by the board, you may sit for the examination at **any** Prometric Test Center in the United States.

### A. Internship

Prior to making your request to take the National Physical Therapy Examination (NPTE), you must be accepted into a PT or PTA internship in accordance with 12 AAC 54.040. The 6 month internship must be approved by the board before you may begin it. The following items must be received by this office for the board's review. Make check or money order payable to the State of Alaska.

1. A completed notarized application and \$150.00 nonrefundable application fee.
2. Initial licensure fee of \$240.00 for Physical Therapist or \$175.00 for Physical Therapy Assistant.
3. Authorization of Release of Records (form 08-4091a)
4. Jurisprudence Questionnaire (form 08-4091b).
5. A Credentials Evaluation Report sent directly by the credentials evaluation service, or if you graduated from a School of Physical Therapy approved by the "Council on Medical Education and Hospitals of the American Medical Association," or the "American Physical Therapy Association," you only need to have your School of Physical Therapy submit certified transcripts (sent directly from school).
6. A Professional Reference from the head of the physical therapy school, or an instructor, physician, supervising physical therapist or supervisor (form 08-4091c).
7. Preceptor Statement for Internship of Foreign-Trained Physical Therapist (form 08-4091g).

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

1. Candidate Evaluation of Internship (form 08-4091i).
2. Preceptor Evaluation of Foreign-Trained Candidate (form 08-4091j).

**It is recommended that you complete all English exams and the NPTE prior to the completion of your internship.**

The board will review the evaluation forms and determine if the applicant has successfully completed the internship. If the board determines that the internship is complete and the applicant has not yet passed the NPTE examination, a temporary permit may be issued in accordance with Part IV.

### B. Examination

When you are ready to take the examination, you must apply directly to the Federation of State Boards of Physical Therapy (FSBPT) at their website, [www.fsbpt.org](http://www.fsbpt.org). Be sure to inform the board that you have registered to take the exam.

Programs under the jurisdiction of the Division of Corporations, Business and Professional Licensing are administered in accordance with the Americans with Disabilities Act. If you require a special accommodation when taking the licensing examination, you must submit a completed Application for Examination Accommodation for Candidates with Disabilities form. This form is available on the division's website: <http://commerce.alaska.gov/dnn/cbpl/ProfessionalLicensing.aspx> or contact the division to request the form.

### C. Licensure

Before a license can be granted, the following items must be received:

1. All of the items listed above under A & B, **AND**;
2. Verification of passage of the English language proficiency examination [TOEFL] (see page 2).
3. Verification of completion of your internship. Candidate Evaluation of Internship (form 08-4091i) and Preceptor Evaluation of Foreign-Trained Candidate (form 08-4091j) must be completed and submitted.

## PART IV – TEMPORARY PERMIT FOR FOREIGN-TRAINED EXAM CANDIDATES

After an applicant has satisfactorily completed the required Alaska internship, the applicant may apply for a temporary permit, but only if the applicant has not taken the national physical therapy examination. The following documents must be in this office before a temporary permit will be issued:

1. Temporary permit fee of \$65.00.
2. All documents and fees listed under “A. Internship” requirement.
3. Verification of passage of the English language proficiency examinations [TOEFL] (see page 2).
4. Temporary Permit Statement of Responsibility for Foreign-Trained Applicant (form 08-4091k).
5. Confirmation from the testing center indicating the date you are scheduled to take the NPTE exam. Request that FSBPT notify the State of Alaska.

**The temporary permit will expire on the date your NPTE Exam Scores are posted and your permanent license cannot be issued unless you have passed all English exams. It is, therefore, recommended that you complete all English exams and the NPTE prior to the completion of your internship.**

### GENERAL INFORMATION:

The application process takes 4 to 6 weeks from the time all documents are received and your application file is complete, so please plan accordingly. Once your application is complete, your application will be reviewed by the Board either by “Mail Vote” or at a Board meeting. Print your name on every page of the application.

All licenses expire on June 30 of even-numbered years regardless of when issued, except new licenses issued within 90 days of the expiration date will be issued to the next biennium.

License fees are subject to change.

If any of the required documents (i.e., transcripts, verifications of licensure, etc.) will be issued under your 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”.

**SOCIAL SECURITY NUMBERS** – Alaska Statute 08.01.060(b) requires an applicant for an occupational license to provide a United States Social Security Number. Applicants who do not have a social security number must complete the Request for Exception from Social Security Number Requirement form located on the Division’s website at <http://commerce.alaska.gov/dnn/cbpl/Home.aspx> or contact the Division to request the form.

**PAYMENT OF CHILD SUPPORT AND STUDENT LOANS** – If the Alaska Child Support Enforcement Division has determined that you are in arrears on child support, or if the Alaska Commission on Post-Secondary Education has determined you are in loan default, you may be issued a nonrenewable temporary license valid for 150 days. Contact Child Support Services at (907) 269-6900 or the Post-Secondary Education office at (907) 465-2962 or 1-800-441-2962 to resolve payment issues.

**PUBLIC INFORMATION** – Please be aware that all information on the initial application form will be available to the public, unless required to be kept confidential by state or federal law. Information about current licensees, including mailing addresses, is available on the division’s website at <http://commerce.alaska.gov/dnn/cbpl/Home.aspx> under License Search.

**“YES” RESPONSES** – A “yes” response does not mean your application will automatically be denied. Applications with a “Yes” response generally require additional time for review. If you respond “Yes” to one of the professional fitness questions in the application, **you must submit the following:**

- **A separate signed and dated explanation, in your own words**
- **Copies of charging documents**
- **Copies of final court documents**
- **For questions 7, 8 & 9, safe to practice statements sent directly to the Division by your medical provider**

**STATUTES AND REGULATIONS** – The complete set of Board of Physical Therapy and Occupational Therapy statutes and regulations is available on the Board’s website at <http://commerce.alaska.gov/dnn/cbpl/ProfessionalLicensing/PhysicalTherapyOccupationalTherapy.aspx> or contact the Division and request a copy by mail.

**DENIAL OF APPLICATION** – Please be aware that the denial of an application for licensure may be reported to any person, professional licensing Board, federal, state or local government agency, or other entity making a relevant inquiry or as may be required by law.

### TO AVOID APPLICATION DELAYS:

- Do not provide mailing envelopes with your requests for verification of licensure, professional reference, verification of work experience or transcripts.
- Review your application fully to ensure you have answered every question completely and followed all of the instructions.
- You may want to keep a copy of your application for your records.
- Do not fax or email your application or any supporting documentation to the Division.
- You must sign and date the application in front of a notary public. Applicant signature date and notary public date must be the same.
- Print all parts of the application packet, including the jurisprudence questionnaire, as single sided documents only.

## APPLICATION CHECKLIST

(Use this checklist to help complete the application requirements for a license in Alaska)

| <b>Foreign-Trained<br/>Physical Therapist and Physical Therapist Assistant<br/>Document</b>   | <b>You Provide<br/>Document</b> | <b>You request other agency<br/>or source to provide<br/>documentation. It must<br/>be mailed directly to our<br/>office from the agency or<br/>source, in their own<br/>envelope</b> |
|---|---------------------------------|---|
| Application with recent photo, signed and notarized (form 08-4091).<br>Notary seal must overlie partial portion of photograph.  | <input type="checkbox"/>        |   |
| Authorization of Release Of Records (form 08-4091a)   | <input type="checkbox"/>        |   |
| Jurisprudence Questionnaire (08-4091b) Name printed on every page,<br>every question answered and every statute or regulation cited.  | <input type="checkbox"/>        |   |
| Request Credential Evaluation from FCCPT, ICD or IERF.  |                                 | <input type="checkbox"/> Source mails to our office   |
| Professional Reference (form 08-4091c) completed by a qualified<br>source.  |                                 | <input type="checkbox"/> Source mails to our office   |
| Verification of Work Experience (form 08-4091d) documenting 60 hours<br>of experience completed <u>no earlier than 24 months prior to the date</u><br>your application is received by our office.   |                                 | <input type="checkbox"/> Source mails to our office   |
| Supervised Work Experience (form 08-4091e) if applying by<br>credentials.   |                                 | <input type="checkbox"/> Source mails to our office   |
| Verifications of Licensure (form 08-4091f) from every jurisdiction you<br>have held a license or certificate. Contact each state or country to find<br>out their fee.   |                                 | <input type="checkbox"/> Source mails to our office   |
| FSBPT Examination Scores (contact FSBPT to have scores released to<br>Alaska).  |                                 | <input type="checkbox"/> FSBPT releases directly<br>to our office   |
| Preceptorship Statement for Internship (form 08-4091g)  |                                 | <input type="checkbox"/> Preceptor mails to our<br>office   |
| If you are applying by Examination and seeking a Temporary Permit,<br>Statement of Responsibility (form 08-4091k) from supervising physical<br>therapist, signed and notarized. Submitted by applicant or supervisor.   | <input type="checkbox"/>        |   |
| Preceptor Credential Review for Federal Government Facilities (form<br>08-4091h) submitted by applicant or supervisor.  | <input type="checkbox"/>        |   |
| Candidate Evaluation of Internship (form 08-4091i)  | <input type="checkbox"/>        |   |
| Preceptor Evaluation (form 08-4091j)  |                                 | <input type="checkbox"/> Preceptor mails to our<br>office   |
| Explanation for any "Yes" responses to the professional fitness<br>question (Section VIII), must include signed and dated letter of<br>explanation, copies of all charging documents and final court<br>documents.  | <input type="checkbox"/>        |   |
| Certified true copy of marriage or divorce certificate if any required<br>documentation will be received in any name other than your current<br>legal name.   | <input type="checkbox"/>        |   |
| Fees enclosed with application. Make check or money order payable to<br>State of Alaska.<br><input type="checkbox"/> Nonrefundable Application Fee<br><input type="checkbox"/> License Fee<br><input type="checkbox"/> Temporary Permit Fee (if applicable)<br><input type="checkbox"/> Wall Certificate Fee (optional) | <input type="checkbox"/>        |   |

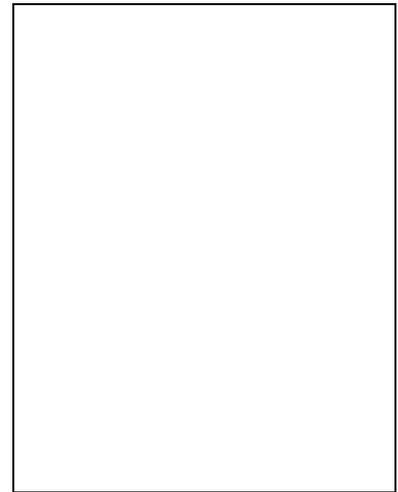


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**FOREIGN-TRAINED PHYSICAL THERAPIST AND  
PHYSICAL THERAPY ASSISTANT LICENSE APPLICATION**

**FEES:** Personal check or money order made payable to State of Alaska, or use the Credit Card Payment Form, found on the Division's website listed above.

\$20.00 Wall Certificate Fee (optional)

**APPLICATION FOR LICENSURE AS:**

- Physical Therapist** – submit \$150.00 nonrefundable application fee and \$240.00 license fee.
- Physical Therapy Assistant** - submit \$150.00 nonrefundable application fee and \$175.00 license fee.

**ARE YOU APPLYING BY:**  Credentials **OR**  Examination

Do you need a temporary permit while awaiting permanent licensure?

No  Yes - \$65.00 fee required for Temporary Permit; Date you plan to begin working \_\_\_\_\_

**It is illegal to begin employment without holding a license, temporary permit, or limited permit.** Do not use this application to apply for a limited permit, you must use the Application for Limited Permit, form #08-4578.

This application must be completed in full. If a section does not apply, write N/A in the space provided. **Please print or type.**

**SECTION I: PERSONAL IDENTIFICATION INFORMATION**

|   |  |  |                        |
|---|--|--|------------------------|
| <b>Full Legal Name</b>  | Last   | First  | Middle                 |
| <b>Address of Record</b>  | Mailing Address  |  |                        |
|   | City   | State  | Zip Code               |
| <b>Telephone</b>  | Work:  | Home:  | Cell:                  |
| <b>Date of Birth</b>  | Month _____ Day _____ Year _____                                   | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female |                        |
| <b>E-Mail</b>   |  |  |                        |
| <b>Other Names Used</b><br>(maiden name, married names)   | <b>Legal Name Changes</b><br>(Provide certified copies of changes) |  |                        |
| <b>APPLICANT: As required by state law, please provide your United States Social Security Number. It is considered CONFIDENTIAL information and is not for public disclosure. If you do not have a United States Social Security Number see page 4 of the instructions.</b> |  |  | Social Security Number |
| <b>Immigration work "visa" number (if applicable)</b>   |  |  |                        |

**SECTION II: LANGUAGE**

|   |   |             |   |                                 |   |
|---|---|-------------|---|---------------------------------|---|
| Have you passed the TOEFL exam?   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <b>TWE?</b> | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <b>TSE (or the SPEAK Exam)?</b> | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| If you have not passed one or all of these examinations, what date are you scheduled to test? |   |             |   |                                 |   |

**SECTION III: EDUCATION:**

|                                   |                               |  |       |     |
|-----------------------------------|-------------------------------|--|-------|-----|
| <b>School of Physical Therapy</b> | Name                          |  |       |     |
|                                   | Address                       | City   | State | Zip |
| <b>Type of Degree Awarded</b>     |                               |  |       |     |
| <b>Date Degree Awarded</b>        | Month_____ Day_____ Year_____ | <b>Your last name (family name) at that date</b> |       |     |

**SECTION IV: PROFESSIONAL CREDENTIALS**

In chronological order starting with the most recent , list every state, U.S. jurisdiction or country in which you currently hold or have ever held a physical therapist or physical therapy assistant LICENSE or PERMIT:

|                    |  |              |  |   |  |                  |  |
|--------------------|--|--------------|--|---|--|------------------|--|
| State/<br>Country: |  | License No.: |  | Original Date of Issue:<br>(mm/dd/yyyy) |  | Expiration Date: |  |
| State/<br>Country: |  | License No.: |  | Original Date of Issue:<br>(mm/dd/yyyy) |  | Expiration Date: |  |
| State/<br>Country: |  | License No.: |  | Original Date of Issue:<br>(mm/dd/yyyy) |  | Expiration Date: |  |
| State/<br>Country: |  | License No.: |  | Original Date of Issue:<br>(mm/dd/yyyy) |  | Expiration Date: |  |
| State/<br>Country: |  | License No.: |  | Original Date of Issue:<br>(mm/dd/yyyy) |  | Expiration Date: |  |

**SECTION V: EXAMINATIONS** List all states or countries and dates (mm/yyyy) in which you took a physical therapy examination. Indicate whether Passed or Failed:

|  |  |                       |  |            |  |   |
|--|--|-----------------------|--|------------|--|---|
| State/<br>Country:                             |  | Exam Administered by: |  | Exam Date: |  | <input type="checkbox"/> Passed <input type="checkbox"/> Failed |
| State/<br>Country:                             |  | Exam Administered by: |  | Exam Date: |  | <input type="checkbox"/> Passed <input type="checkbox"/> Failed |
| State/<br>Country:                             |  | Exam Administered by: |  | Exam Date: |  | <input type="checkbox"/> Passed <input type="checkbox"/> Failed |
| Your last name at time of passing examination: |  |                       |  |            |  |   |

**SECTION VI: ALASKA EMPLOYMENT**

|   |                             |   |      |       |     |
|---|-----------------------------|---|------|-------|-----|
| <b>Have you secured employment in Alaska:</b>       | <input type="checkbox"/> NO | <input type="checkbox"/> YES; If YES Provide: |      |       |     |
| <b>Alaska Employer Name</b>                         | Name                        |   |      |       |     |
| <b>Alaska Employer Mailing and Physical Address</b> | Mailing Address             |   | City | State | Zip |
|   | Physical Address            |   | City | State | Zip |
| <b>Alaska Employer Telephone Number</b>             |                             | <b>Expected Beginning Date of Employment:</b> |      |       |     |

|                        |              |
|------------------------|--------------|
| <b>Applicant Name:</b> | <b>Date:</b> |
|------------------------|--------------|

**SECTION VII: TEMPORARY PERMIT**

If applying for a Temporary Permit by Examination, provide:

|   |   |                     |           |
|---|---|---------------------|-----------|
| <b>Supervising Therapist</b>  | Name  | <b>License No.:</b> |           |
| <b>Address to mail temporary permit if NOT the same as address listed on page 1</b> | <input type="checkbox"/> Employer listed on page 2 <input type="checkbox"/> Other (enter address below) |                     |           |
|   | Address   | City                | State Zip |

**SECTION VIII: OCCUPATIONAL DATA PRACTICE HISTORY: Beginning with current position, provide a chronological listing of all practice related activities, and back for the last ten years.**

**Do not attach a resume; we require the use of this form. If you are a traveler, do not put “various locations”, you must report every facility location/city and state in which you have practiced.**

**Please explain any gap from practice of more than 120 days’ duration. If practice began prior to permanent licensure, provide permit number and date issued. If needed, you may make additional copies of this page.**

|   |  |  |  |   |
|---|--|--|--|---|
| <b>Employer and Institution at location of practice</b> | Facility Name                            |  |  |   |
|   | Location (City, State, or Other Country) |  |  |   |
| <b>Dates of Practice (mm/yyyy)</b>                      | From:<br>To:                             | <b>Original Date License or Permit was Issued:</b> |  | <b>License or Permit from the State of:</b> |
| <b>Additional Comments</b>                              |  |  |  |   |

|   |  |  |  |   |
|---|--|--|--|---|
| <b>Employer and Institution at location of practice</b> | Facility Name                            |  |  |   |
|   | Location (City, State, or Other Country) |  |  |   |
| <b>Dates of Practice (mm/yyyy)</b>                      | From:<br>To:                             | <b>Original Date License or Permit was Issued:</b> |  | <b>License or Permit from the State of:</b> |
| <b>Additional Comments</b>                              |  |  |  |   |

|   |  |  |  |   |
|---|--|--|--|---|
| <b>Employer and Institution at location of practice</b> | Facility Name                            |  |  |   |
|   | Location (City, State, or Other Country) |  |  |   |
| <b>Dates of Practice (mm/yyyy)</b>                      | From:<br>To:                             | <b>Original Date License or Permit was Issued:</b> |  | <b>License or Permit from the State of:</b> |
| <b>Additional Comments</b>                              |  |  |  |   |

|   |  |  |  |   |
|---|--|--|--|---|
| <b>Employer and Institution at location of practice</b> | Facility Name                            |  |  |   |
|   | Location (City, State, or Other Country) |  |  |   |
| <b>Dates of Practice (mm/yyyy)</b>                      | From:<br>To:                             | <b>Original Date License or Permit was Issued:</b> |  | <b>License or Permit from the State of:</b> |
| <b>Additional Comments</b>                              |  |  |  |   |

|                        |              |
|------------------------|--------------|
| <b>Applicant Name:</b> | <b>Date:</b> |
|------------------------|--------------|



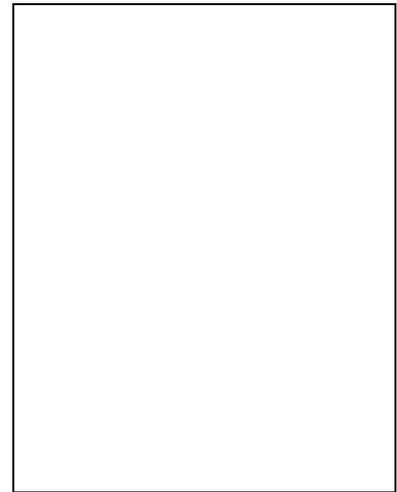


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Phone: (907) 465-2580 \* Fax: (907) 465-2974
Email: license@alaska.gov
Website: ProfessionalLicense.Alaska.Gov/PhysicalTherapyOccupationalTherapy



AUTHORIZATION FOR RELEASE OF RECORDS

TO WHOM IT MAY CONCERN:

I, \_\_\_\_\_, residing at \_\_\_\_\_

\_\_\_\_\_, authorize the Alaska Division of Corporations, Business and Professional Licensing and its investigators to examine my medical, employment, education records, and records pertaining to litigation, judgments, suits and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of all such records pertaining to me to the Alaska Division of Corporations, Business and Professional Licensing and its investigators.

I authorize the division to discuss my records with persons or organizations which are considered appropriate by the division in connection with an official investigation, and to provide copies of my records to those persons or organizations deemed appropriate by the division.

This release also applies to any documents or records which contain information pertaining to psychiatric, drug or alcohol evaluation, diagnosis or treatment received by me and which were prepared or made in conjunction with, or under the authority or guidance of any local, state, or federal law which relates to psychiatric, drug or alcohol evaluation, diagnosis, or treatment.

I request that upon presentation of this release, or a Certified True Copy, that you provide copies of those records to the division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska. This authorization is given expressly in connection with my application for a license or permit to practice as a physical therapist, physical therapy assistant, occupational therapy, or occupational therapy assistant in Alaska.

Home Telephone: \_\_\_\_\_

Work Telephone: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

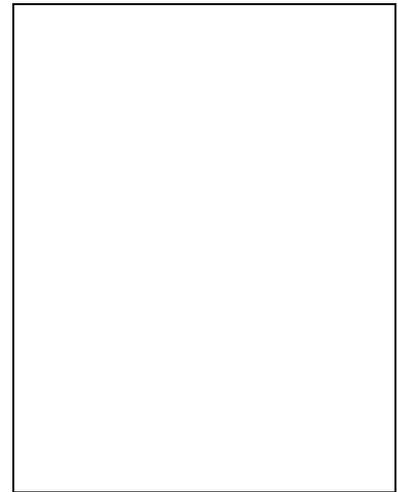


THE STATE of ALASKA

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

Board of Physical Therapy and Occupational Therapy

State Office Building, 333 Willoughby Avenue, 9th Floor
PO Box 110806, Juneau, AK 99811-0806
Phone: (907) 465-2580 \* Fax: (907) 465-2974
Email: license@alaska.gov
Website: ProfessionalLicense.Alaska.Gov/PhysicalTherapyOccupationalTherapy



JURISPRUDENCE QUESTIONNAIRE FOR PHYSICAL THERAPY APPLICANTS

Applicant Name: \_\_\_\_\_

All applicants for licensure must complete the following questionnaire prepared by the Board of Physical Therapy and Occupational Therapy. The questions cover the provisions of AS 08.84 and 12 AAC 54 (the board's specific statutes and regulations). Centralized Statute 08.01 is also referenced. The answers to the questions will be found by reviewing the statute and regulation booklets published by the board (you can view and download the booklets from the board's website at ProfessionalLicense.Alaska.Gov/PhysicalTherapyOccupationalTherapy. Use the statutes and regulations to determine the correct answer for each question. Circle your multiple choice answers and cite the statute or regulation where the answer was found. The questionnaire will not be graded. If you fail to circle an answer or cite the law, your application for licensure will be considered incomplete and the questionnaire will be returned to you for completion.

Circle the letter of the best answer for all items

AND

Cite the statute or regulations from which you obtained your answer

- 1. The board may take the following actions singularly or in combination
a. Refuse renewal
b. Revoke
c. Suspend
d. All of the above
e Cite Statute AS 08.84. \_\_\_\_\_

2. According to the Centralized Statutes 08.01.075, disciplinary powers of the board may include
a. Impose a civil fine not to exceed \$1,000
b. Impose a civil fine not to exceed \$3,000
c. Impose a civil fine not to exceed \$5,000
d. Impose a civil fine not to exceed \$10,000
e Cite Statute 08.01.075 \_\_\_\_\_

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
a. has attempted to obtain a license by material misrepresentation
b. has continued to practice physical therapy after becoming unfit due to physical or mental disability
c. has failed to refer a patient to another qualified professional when the patient's condition is beyond the training or ability of the person
d. uses drugs or alcohol in any manner that affects the person's ability to practice physical therapy safely
e. all of the above
e Cite Statute AS 08.84. \_\_\_\_\_

Name: \_\_\_\_\_

4. An individual who practices without the appropriate license (including practicing with a lapsed license) is guilty of a class A misdemeanor
- a. class B misdemeanor
  - b. class C misdemeanor
  - c. felony
- è Cite Statute AS 08.84. \_\_\_\_\_
5. A physical therapist or physical therapy assistant applicant by examination who holds a temporary permit must practice under the supervision of a licensed physical therapist.
- a. False
  - b. True
- è Cite Regulation 12 AAC 54. \_\_\_\_\_
6. A physical therapist or physical therapy 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.
- a. 16
  - b. 20
  - c. 24
  - d. 28
- è Cite Regulation 12 AAC 54. \_\_\_\_\_
7. A physical therapist may concurrently supervise a maximum of how many physical therapy assistants, physical therapy aides, foreign-trained candidates, students, permittees or any combination thereof?
- a. 3
  - b. 4
  - c. 6
  - d. 8
- è Cite Regulation 12 AAC 54. \_\_\_\_\_
8. An applicant for renewal of a physical therapist or physical therapy assistant license shall document having provided physical therapy services for at least \_\_\_\_\_ hours during the concluding licensing period.
- a. 30
  - b. 60
  - c. 120
  - d. 150
- è Cite Regulation 12 AAC 54. \_\_\_\_\_
9. Records of continuing education must be retained from the date of completion for
- a. 2 years
  - b. 3 years
  - c. 5 years
  - d. 7 years
- è Cite Regulation 12 AAC 54. \_\_\_\_\_
10. It is the responsibility of the \_\_\_\_\_ to notify the Division of Corporations, Business and Professional Licensing when a change in address occurs for a licensee.
- a. employer
  - b. direct supervisor
  - c. licensee
  - d. all of the above
- è Cite Regulation 12 AAC 54. \_\_\_\_\_

Name: \_\_\_\_\_

11. A licensee selected for audit of continuing competency requirements shall submit substantiating documentation within \_\_\_\_\_ after the date of notification by the division.
- a. 30 days
  - b. 60 days
  - c. 90 days
  - d. 120 days
- è Cite Regulation 12 AAC 54. \_\_\_\_\_
12. If an applicant for renewal is uncertain whether a particular continuing education opportunity will meet the standards for renewal, the applicant may request board approval before claiming those hours.
- a. The applicant may request board approval *after* submitting the application for license renewal
  - b. The applicant may request board approval *at the same time as* submitting the application for license renewal
  - c. The applicant may request board approval *before* submitting the application for license renewal
  - d. The applicant *should not submit* that particular continuing education opportunity when submitting the application for license renewal
- è Cite Regulation 12 AAC 54. \_\_\_\_\_
13. Physical therapists and physical therapist assistants must adhere to the physical therapy standards including the National Professional Core Values and Ethical Standards and the Alaska Board of Physical Therapy and Occupational Therapy Principles of Practice.
- a. False
  - b. True
- è Cite Regulation 12 AAC 54. \_\_\_\_\_
14. For continuing education activities to meet the standards of renewal, at least one half must be recognized by
- a. American Physical Therapy Association (APTA)
  - b. Other state physical therapy associations or other physical therapy licensing boards
  - c. Federation of State Boards of Physical Therapy (FSBPT)
  - d. All of the above
- è Cite Regulation 12 AAC 54. \_\_\_\_\_
15. Continual onsite supervision means that the physical therapist or physical therapy assistant \_\_\_\_\_
- a. is immediately available
  - b. is present in the department or facility where services are being provided
  - c. maintains continual oversight of patient-related duties
  - d. all of the above
- è Cite Regulation 12 AAC 54. \_\_\_\_\_
16. The license or permit or a copy of the license or permit must be
- a. kept in the personnel file of the licensee or permit holder
  - b. kept with the practicing therapist at all times
  - c. posted in a conspicuous location in the licensee's primary place of business
  - d. posted somewhere in the place of business
- è Cite Regulation 12 AAC 54. \_\_\_\_\_
17. 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 to take the examination.
- a. False
  - b. True
- è Cite Statute AS 08.84. \_\_\_\_\_

Name: \_\_\_\_\_

18. If the licensed physical therapist agrees to supervise a physical therapy assistant, the supervising physical therapist shall.
- a. fully document the supervision provided
  - b. include a record of all consultations provided in each patient's file
  - c. maintain records of supervision at the physical therapy assistant's place of employment
  - d. 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 therapy assistant being supervised
  - e. all of the above

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

19. 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
  - b. Name, mailing address, and signature of the instructor, sponsor or other verifier
  - c. Name of the licensee and the amount of continuing competency credit awarded
  - d. All of the above

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

20. 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 therapy assistant AND must be directly related to the skills and knowledge required to implement the principles and methods of physical therapy.
- a. False
  - b. True

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

21. The physical therapist and/or physical therapy assistant must be licensed and must be present in the State of Alaska to perform telerehabilitation.
- c. False
  - d. True

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

**Did you print your name on each page of the exam?**

**DID YOU REMEMBER TO CIRCLE EACH ANSWER AND  
CITE THE STATUTE OR REGULATION?**

If you fail to circle any of the multiple choice answers or fail to cite the statute or regulation to back your answers, your application for licensure will be considered incomplete and the questionnaire will be returned to you for completion.

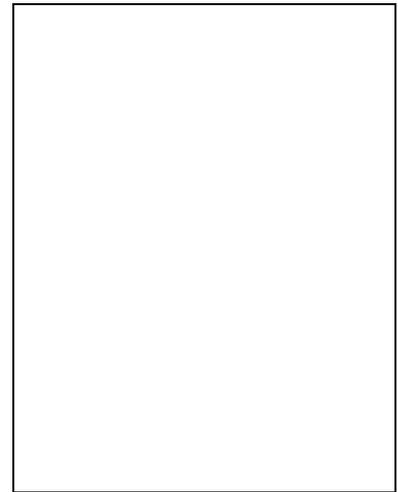


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PROFESSIONAL REFERENCE

Dear \_\_\_\_\_:

I am applying for a license to practice physical therapy in the State of Alaska. Please complete the below reference. Return this form to the State of Alaska at the address shown above.

Thank you for your assistance.

Applicant Signature: \_\_\_\_\_

Applicant Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_
\_\_\_\_\_

Physical Therapists or Physical Therapy Assistants applying by examination must provide a professional reference from the head of the physical therapy school, or an instructor, physician, supervising physical therapist or supervisor.

Physical Therapists or Physical Therapy Assistants applying by credentials must provide a professional reference from the head of the physical therapy school from which the applicant graduated, or an instructor, physician, or physical therapist other than the physical therapist under which the applicant served an internship.

This form will be rejected if any of the following section is completed and/or submitted to the Division by the applicant.

The following information must be completed in full and sent directly to the Division by the professional reference.

I certify that I was professionally associated with \_\_\_\_\_ (Name of Applicant)

from \_\_\_\_\_ (month/year) to \_\_\_\_\_ (month/year), and

I recommend the applicant as being professionally capable, reliable, of good moral character and worthy of confidence. The State of Alaska believes a license to practice physical therapy carries important responsibilities. Please comment on the applicant's qualifications, ability, character, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

My professional relationship to the applicant was: (check title below):

- Head of the Physical Therapy School
- Instructor
- Physician
- Supervising Physical Therapist
- Supervisor

I was the applicant's internship supervisor:

- Yes
- No

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Printed Name License Number (if applicable)

\_\_\_\_\_  
Institution/Clinic Where Employed Title

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Business Telephone

\_\_\_\_\_  
Email Address

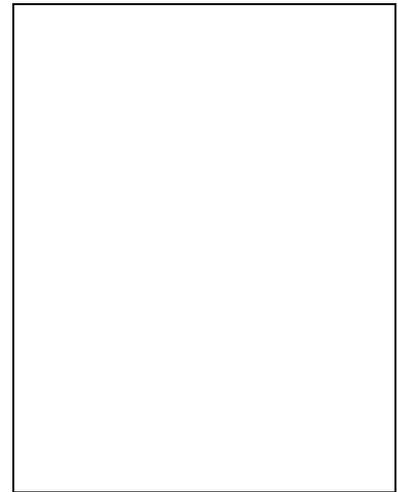


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VERIFICATION OF WORKING EXPERIENCE

Dear \_\_\_\_\_:

I am applying for a license to practice physical therapy in the State of Alaska. Please complete the below reference. Return this form to the State of Alaska at the address shown above.

Thank you for your assistance.

Applicant Signature: \_\_\_\_\_

Applicant Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

NOTE: To avoid delays, do not provide your reference with a mailing envelope. This form must be sent directly to the Division from your professional reference in their own envelope.

This form will be rejected if any of the section below is completed and/or submitted to the Division by the applicant.

The below information must be fully completed in full and sent directly to the Division by the applicant's employer, supervisor, or the Human Resource Manager at the place of employment.

\*12 AAC 54.100(5)(A) requires verification of having been employed in physical therapy service at least 60 hours within 24 months IMMEDIATELY PRECEDING the date the application for licensure in Alaska is received by the department.

I, \_\_\_\_\_, attest that \_\_\_\_\_

(Name of Employer or Supervisor)

(Name of Applicant)

is/was employed at \_\_\_\_\_

(Name of Institution/Professional Clinic, etc.)

and provided at least 60 hours of (check one): [ ] physical therapy services or [ ] physical therapy assistant services

within the immediate past 24-month period from \_\_\_\_\_ to \_\_\_\_\_

month/day/year

month/day/year

Average number of hours of practice per week = \_\_\_\_\_

NOTE: The hours of practice should not be outside of the required reporting period. If employed 24 months prior to the date the application is received, then only report for the immediate past 24 months.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ License Number (if applicable) \_\_\_\_\_

Institution/Clinic Where Employed \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_

Business Telephone \_\_\_\_\_

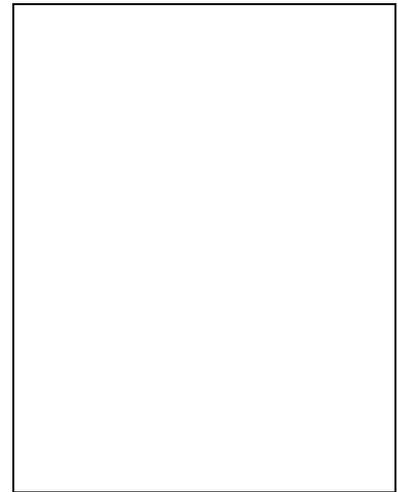


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SUPERVISED WORK EXPERIENCE VERIFICATION
(To be used only for licensure by credentials)

Dear Supervisor:

I am applying for a license to practice physical therapy as a foreign-trained therapist in the State of Alaska. I am required to provide evidence of supervised work to the State Physical Therapy and Occupational Therapy Board. Please provide the information requested below to the State of Alaska at the address shown above. Thank you for your assistance.

Applicant Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

The information below must be completed by your supervising physical therapist; it may not be completed or returned by the applicant. Evidence of six (6) months supervised work experience (12 AAC 54.110(4))

I certify that I supervised \_\_\_\_\_ (Name of Applicant)

from \_\_\_\_\_ to \_\_\_\_\_, and I recommend the applicant as being professionally capable, reliable, of good moral character and worthy of confidence.

The State of Alaska believes a license to practice physical therapy carries important responsibilities. Please comment on the applicant's qualifications, ability, character, etc.:

\_\_\_\_\_  
\_\_\_\_\_

Signature Date

Printed Name License Number (if applicable)

Institution/Clinic Where Employed Title

Business Telephone

Mailing Address

Email Address

City State Zip Code

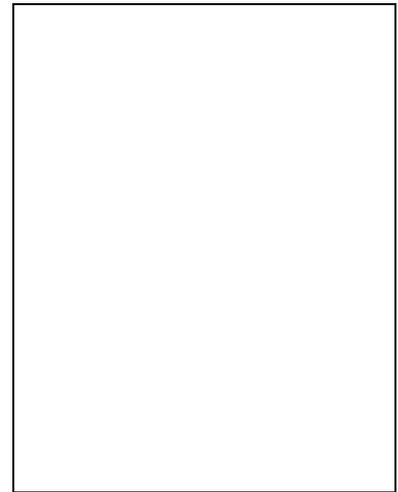


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VERIFICATION OF LICENSURE

APPLICANT: COMPLETE TOP HALF OF THIS FORM AND FORWARD IT TO THE LICENSING BOARD(S) IN EVERY JURISDICTION WHERE YOU ARE OR HAVE BEEN LICENSED. Some states require a fee for completion of license verification. We recommend you check with the state board prior to submitting this form to them for completion.

I am applying to the State of Alaska for a license to practice Physical Therapy. The Board requires verification of my license in each jurisdiction in which I hold or have held licenses.

Form fields: Last Name, First Name, Middle, Mailing Address, License Number, City, State, ZIP Code, E-mail Address, Daytime Phone Number

I hereby request and authorize the State of \_\_\_\_\_ to provide any and all pertinent information requested in this form to the Alaska State Physical Therapy and Occupational Therapy Board to complete an application filed with that agency.

Applicant Signature, Date

TO STATE BOARD Please complete and certify this form and return it directly to the Alaska State Physical Therapy and Occupational Therapy Board at the address listed on the top of this form. You may use your state verification of license certificate if it includes the following information.

Licensing Jurisdiction \_\_\_\_\_

Name of Licensee \_\_\_\_\_

Licensed By (reciprocity, examination, etc.) \_\_\_\_\_

If licensed by examination, what examination did the licensee pass? \_\_\_\_\_

License Number \_\_\_\_\_ Original Issue Date \_\_\_\_\_ Expiration Date \_\_\_\_\_ Periods of Lapse \_\_\_\_\_

Has the license ever been revoked, suspended, placed on probation, or restricted in any way? Yes No
If yes, please enclose an explanation or documentation.

Is the licensee the subject of a pending disciplinary proceeding? Yes No

Has the licensee ever been the subject of an unresolved complaint, review procedure, or disciplinary action?.....  Yes  No  
If yes, please enclose an explanation or documentation.

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Printed Name \_\_\_\_\_

Signature \_\_\_\_\_

Title \_\_\_\_\_

Date \_\_\_\_\_ Phone Number \_\_\_\_\_

E-mail Address \_\_\_\_\_

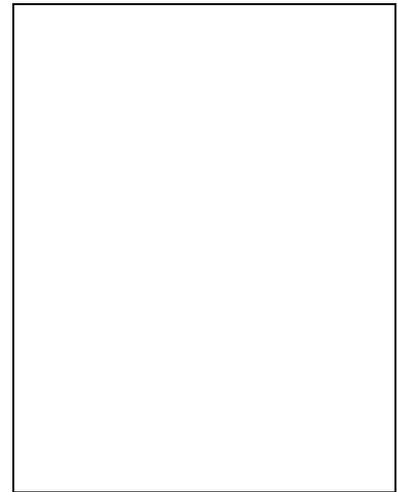


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PRECEPTORSHIP STATEMENT FOR INTERNSHIP OF FOREIGN-TRAINED PHYSICAL THERAPIST

This internship must be reviewed and approved by the board before the internship can take place. DO NOT BEGIN INTERNSHIP UNTIL APPROVED BY THE BOARD. Internship must be for a minimum of six months averaging not less than 35 hours per week for a combined total of 910 hours.

1. Name of Facility:
Type of Facility:

2. Mailing Address:
City: State: ZIP Code:
Telephone:

3. Date internship will start: (Note: You must have board approval before internship can begin.)
Date facility anticipates the internship will be completed:

4. Name of Supervisor:
Present Position:
Years Experience:

5. Physical Therapists on staff in department and number of hours worked per week: (Must have at least two full-time licensed physical therapists on staff)

Name of Physical Therapist PT license number Number of hours worked per week

Name of Physical Therapist PT license number Number of hours worked per week

Name of Physical Therapist PT license number Number of hours worked per week

6. Other staff in department:

7. 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.)

- |                     |                    |              |                                  |
|---------------------|--------------------|--------------|----------------------------------|
| _____ A. Modalities | _____ C. Chronic   | - orthopedic | _____ E. Sterile technique       |
|                     |                    | - neurologic | (wounds, burns, frostbite, etc.) |
| _____ B. Acute      | _____ D. Pediatric | - orthopedic | _____ F. Other (list)            |
| - orthopedic        |                    | - neurologic | _____                            |
| - neurologic        |                    |              | _____                            |

8. Describe the experience expected for the foreign-trained therapist (therapist is not expected necessarily to treat all types of patients, but must treat a variety of patients). Experience should be in any of the cases directed in #7 above.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Approximate number of patients seen per day or week for preceptor \_\_\_\_\_;  
for department \_\_\_\_\_.

10. Provide brief descriptions of other programs, services, activities at facility (e.g., rounds, staffings, continuing education, etc.).

| ACTIVITY | FREQUENCY |
|----------|-----------|
| _____    | _____     |
| _____    | _____     |
| _____    | _____     |
| _____    | _____     |

11. Possibilities for experience at other agencies/facilities: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, the undersigned, agree to act as preceptor for \_\_\_\_\_,  
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-trained 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.

\_\_\_\_\_  
Signature of Preceptor Date

Please return completed form to:  
Department of Commerce, Community,  
and Economic Development  
Division of Corporations, Business  
and Professional Licensing  
P.O. Box 110806  
Juneau, AK 99811-0806

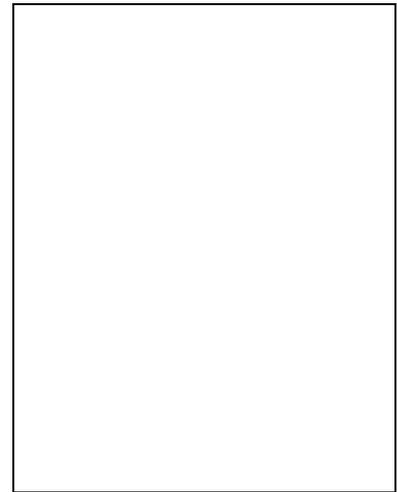


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PRECEPTOR CREDENTIALS REVIEW
(For Federal Government Facilities: PHS and Military)

To be completed by the physical therapist employed by a federal facility, who wishes to serve as a preceptor of the internship required by AS 08.84.032(2), but who is not licensed in the State of Alaska.

- 1. Name of Preceptor:
2. Mailing Address:
City: State: ZIP Code:
3. Telephone:
4. Education:

Table with 4 columns: Name of School, Location, Dates (From/To), Degree or Number of Hours

5. Professional Experience (last five years):

Table with 3 columns: Name and Address, Position, Dates

6. Have you ever taken a national examination for physical therapist? Yes No

Administered by:

Examination date: Place administered:

7. Licensing Background – List all states in which you are licensed:

| State | Date Issued | Status |
|-------|-------------|--------|
| _____ | _____       | _____  |
| _____ | _____       | _____  |
| _____ | _____       | _____  |

8. GENERAL INFORMATION - If you answer “yes” to any question, please explain in full on a separate signed statement and enclose applicable legal documentation.

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 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? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever 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"/> | <input type="checkbox"/> |
| 3. Have you ever been denied the privilege of taking an examination before any state Physical Therapy Board? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever 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"/> | <input type="checkbox"/> |
| 5. Have you ever been convicted of a violation of any federal or state narcotic laws? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had any malpractice settlements or judgments paid on your behalf? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you now or have you been in the last five years addicted to, or excessively used, or misused, alcohol, narcotics, barbiturates or habit-forming drugs? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you now or have you been in the last five years treated for bipolar disorder, schizophrenia, paranoia, psychotic disorder, substance abuse, depression (except for situational or reactive depression) or any other mental or emotional illness? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have a physical disability which could affect your ability to practice physical therapy? .....   | <input type="checkbox"/> | <input type="checkbox"/> |

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

**I hereby certify that the information in this application is true and correct to the best of my knowledge. I understand that any false information may result in failure to obtain approval as a preceptor.**

\_\_\_\_\_  
Signature of Applicant

SUBSCRIBED AND SWORN before me, a Notary Public, in and for the State of \_\_\_\_\_  
this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public

NOTARY SEAL

My Commission Expires: \_\_\_\_\_

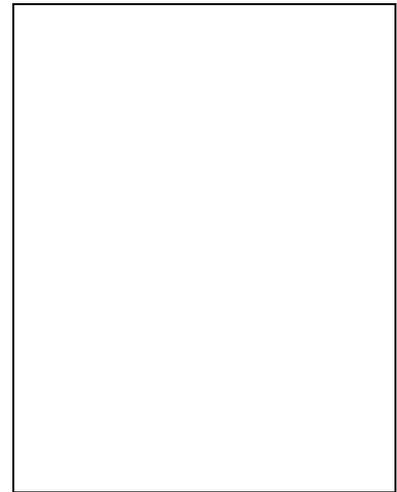


THE STATE of ALASKA

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

Board of Physical Therapy and Occupational Therapy

State Office Building, 333 Willoughby Avenue, 9th Floor
PO Box 110806, Juneau, AK 99811-0806
Phone: (907) 465-2580 \* Fax: (907) 465-2974
Email: license@alaska.gov
Website: ProfessionalLicense.Alaska.Gov/PhysicalTherapyOccupationalTherapy



CANDIDATE EVALUATION OF INTERNSHIP

To be mailed directly to the Division by the candidate

Name of Candidate: \_\_\_\_\_

Name of Facility: \_\_\_\_\_

Date of Internship: \_\_\_\_\_

Describe quality and adequacy of the following items; please use back of sheet or second page for extra space.

- 1. Physical Setting (Facility)
a. Space/Layout: \_\_\_\_\_
b. Equipment: \_\_\_\_\_
c. Other: \_\_\_\_\_
2. Patient Exposure
a. Number of Patients: \_\_\_\_\_
b. Variety: \_\_\_\_\_
c. Scheduling: \_\_\_\_\_
3. Department of Administration
a. Level of Supervision: \_\_\_\_\_
b. Fairness of Supervision: \_\_\_\_\_
c. Adequacy of Staffing: \_\_\_\_\_
d. Staff Relationships: \_\_\_\_\_
e. Standards of Treatment: \_\_\_\_\_

COMMENTS:

1. Was your role defined/understood at the beginning and throughout the internship? Was it appropriate?

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2. What were the positive and negative aspects of this experience?

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3. How would you improve the experience?

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OTHER COMMENTS: \_\_\_\_\_

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

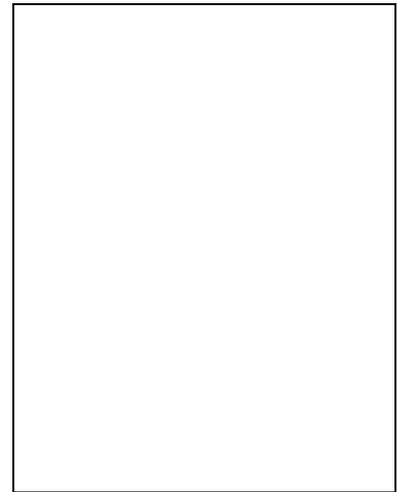


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PRECEPTOR EVALUATION OF FOREIGN-TRAINED CANDIDATE

To be mailed directly to the Division by the preceptor

Preceptorship For: P.T. \_\_\_\_\_

P.T.A. \_\_\_\_\_

Evaluation: Interim \_\_\_\_\_

Final \_\_\_\_\_

Table with 2 columns: Rating (1-4, N/A, N/E) and Description (above average, average, below average, unacceptable, not applicable, no experience)

Name of Candidate: \_\_\_\_\_

Name of Preceptor: \_\_\_\_\_

Dates Inclusive: \_\_\_\_\_

Number of Hours Worked Per Week: \_\_\_\_\_

List duties performed by candidate during preceptorship:

List types of patients actually evaluated and treated by the candidate:

Experience with other department/agencies (describe in detail on separate sheet, if needed):

Using the Rating table above, rate and/or describe candidate's performance in following areas:

1. Quantity of work and effective use of time:

2. Quality of work:

\_\_\_\_\_ a. Modalities \_\_\_\_\_

\_\_\_\_\_ b. Acute — orthopedics \_\_\_\_\_

— neurologic \_\_\_\_\_

\_\_\_\_\_ c. Chronic — orthopedics \_\_\_\_\_

— neurologic \_\_\_\_\_

\_\_\_\_\_ d. Pediatric — orthopedics \_\_\_\_\_

— neurologic \_\_\_\_\_

\_\_\_\_\_ e. Sterile technique \_\_\_\_\_

\_\_\_\_\_ f. Other \_\_\_\_\_

3. Communication Skills:

\_\_\_\_\_ a. With patients and families (verbal and written) \_\_\_\_\_

\_\_\_\_\_ b. With staff \_\_\_\_\_

\_\_\_\_\_ c. Charting \_\_\_\_\_

4. Professionalism:

\_\_\_\_\_ a. Personal presentation \_\_\_\_\_

\_\_\_\_\_ b. Ability to work with staff, physicians, and other departments/agencies \_\_\_\_\_

\_\_\_\_\_ c. Judgement \_\_\_\_\_

\_\_\_\_\_ d. Ethics \_\_\_\_\_

5. Treatment Planning and Implementation:

\_\_\_\_\_ a. Scheduling \_\_\_\_\_

\_\_\_\_\_ b. Goal setting \_\_\_\_\_

\_\_\_\_\_ c. Implementation and discharge \_\_\_\_\_

6. English Proficiency: Is candidate's first language English?  Yes  No

\_\_\_\_\_ a. Verbal \_\_\_\_\_

\_\_\_\_\_ b. Written \_\_\_\_\_

7. \_\_\_\_\_ Is the intern/candidate ready to take the NPTE/NPTAE?  Yes  No

COMMENTS:

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Do you feel this candidate's work is adequate for independent practice?  Yes  No

If no, why? \_\_\_\_\_

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Overall Rating:  Excellent  Good  Fair  Poor

Other Comments:

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Signature of Candidate  
(for interim evaluation only)

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Date

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Signature of Preceptor

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Date

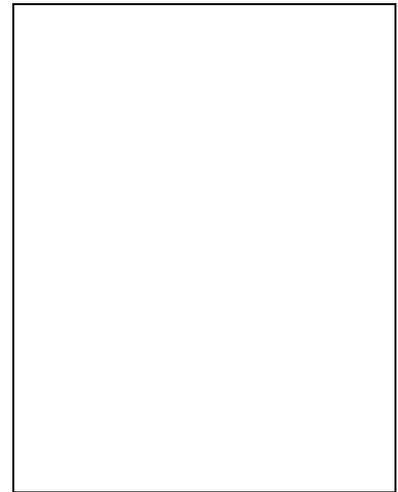


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TEMPORARY PERMIT STATEMENT OF RESPONSIBILITY FOR FOREIGN-TRAINED EXAMINATION APPLICANT

This form must be submitted after a foreign-trained applicant has completed the six-month internship.

Date: \_\_\_\_\_

To State Physical Therapy and Occupational Therapy Board:

I, \_\_\_\_\_, will assume the full responsibility of supervising
(Print Supervisor Name)

\_\_\_\_\_ in the practice of physical therapy.

Name of Facility Where Supervision will take place

located at \_\_\_\_\_

Mailing Address: \_\_\_\_\_

This supervision will be held in compliance with the statutes and regulations set forth by the State Physical Therapy and Occupational Therapy Board.

I understand that the applicant's temporary permit will expire when the results of the examination for which the applicant is scheduled are published. ("Published" means the date of notification of examination results from the Division of Corporations, Business and Professional Licensing to the applicant.) If the applicant has not yet passed the required English exams at this point, they cannot obtain a permanent license. 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.

Signature of Supervisor

Alaska Physical Therapy License Number: \_\_\_\_\_

SUBSCRIBED AND SWORN before me, a Notary Public, in and for the State of \_\_\_\_\_

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

NOTARY SEAL

Notary Public

My Commission Expires: \_\_\_\_\_