



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) 465-2550 • Fax: (907) 465-2974

Email: license@alaska.gov

Website: ProfessionalLicense.Alaska.Gov/PhysicalTherapyOccupationalTherapy

Physical Therapy and Occupational Therapy Limited Permit Application

- A person may apply for a limited permit to practice physical therapy or occupational therapy in the State of Alaska under the provisions of AS 08.84.075.
- If you are seeking permanent licensure or are a foreign-trained physical therapist, do not complete this application.
- Allow eight weeks from the time your file is complete for processing the application. All required forms and documentation must be submitted to the division directly from the required source or they will be rejected.
- If any of the required documents (i.e., verification of licensure, etc.) will be issued under your former name, submit a notarized document of the name change (i.e. marriage license/court documents). It must be notarized as a "certified true copy of the original document".

Qualifications for a Limited Permit

The Board may issue a limited permit to practice in the state as a visiting, nonresident:

1. physical therapist or physical therapy assistant, per AS 08.84.075(b)
2. occupational therapy or occupational therapy assistant, per AS 08.84.075(a)

A limited permit is valid for a period not exceeding 120 consecutive days in a calendar year. A person may not have been denied licensure in this state and may not receive more than three limited permits to practice physical or occupational therapy during the person's lifetime.

The following documents must be in this office before the board will consider your application for a Limited Permit:

1. A completed notarized limited permit application (form #08-4578).
2. \$150.00 nonrefundable application fee.
3. \$65.00 limited permit fee.
4. Verification of licensure mailed directly to this office from a state where you hold a current license to practice physical therapy or occupational therapy (form 08-4578c).

— or —

an occupational therapist or occupational therapy assistant may provide certification by the AOTA instead of verification of licensure from a state where you hold a current license.

5. Statement signed and dated by the applicant that confirms the following (form 08-4578b):
 - (a) Dates applicant intends to work in Alaska;
 - (b) Name and location of facility where applicant intends to work in Alaska; and
 - (c) Applicant will not practice for more than 120 consecutive days in the calendar year for which the permit is issued.
6. Authorization for Release of Records (form 08-4578a).



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General Instructions

- If you are seeking a limited permit, or if you are a foreign-trained therapist, do not complete this application. You may download those applications from the Board's website.
- Appropriate fees must accompany applications before initial screening can begin. All fees may be paid with check or money order, made payable to the State of Alaska, or credit card. To pay by credit card, use the Credit Card Payment form, found on the Division's website at: ProfessionalLicense.Alaska.Gov
- 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."
- Do not fax or email your application to the Division.
- An incomplete application or any unusual circumstances noted in the application may require additional processing time.
- While we understand your desire to conclude this process as quickly as possible, our licensing staff is responsible for reviewing many files and cannot complete the application process if required documents are missing. It is your responsibility to ensure those documents are submitted to our office.
- 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 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.
- If you received this application from a source 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 applications from the Board's website. Applications will be rejected if not the current version.

**IT IS ILLEGAL TO PRACTICE IN PHYSICAL THERAPY OR OCCUPATIONAL THERAPY
IN ALASKA WITHOUT A VALID LICENSE — PLEASE PLAN AHEAD**



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Limited Permit Application

Physical Therapy and Occupational Therapy

PART I Applicant Information			
Applying For:	<input type="checkbox"/> Physical Therapist	<input type="checkbox"/> Physical Therapist Assistant	
	<input type="checkbox"/> Occupational Therapist	<input type="checkbox"/> Occupational Therapist Assistant	
Required Fees:	<input type="checkbox"/> Nonrefundable Application Fee	\$150.00	
	<input type="checkbox"/> Limited Permit Fee	\$65.00	
Full Legal Name:			
Other Names Used:	If any of the required documents (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."		
Mailing Address:	Address: _____		
	City: _____	State: _____	ZIP: _____
Work Phone:		Cell Phone:	
Birthdate:		Gender:	
EMAIL AGREEMENT: By choosing to receive correspondence on any matter affecting your license or other business with the Alaska Division of Corporations, Business and Professional Licensing by email, you agree to notify the Division in writing when your email address changes. You understand that failure to check your email address or to keep it in good standing may result in an inability to receive crucial information, potentially resulting in the inability to obtain or retain licensure.			
Email Address:			<input type="checkbox"/> Send my Correspondence by Email <input type="checkbox"/> Send my Correspondence by US Mail
SOCIAL SECURITY NUMBER: As required by state law, please provide your United States Social Security Number. It is considered confidential information and is not for public disclosure; it may be used to verify interstate licensure.			

PART II Education: Physical Therapy or Occupational Therapy School

Name of School:	
Address of School:	
First Professional Degree:	
Date Degree Awarded:	
Your Name When Degree Awarded:	

PART III Examinations

List all states and dates where you took the national physical therapy or occupational therapy examination.

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 IV Alaska Employment

Have you secured employment in Alaska? Yes No

If "Yes," expected beginning date of employment: _____

Alaska Employer Name:	
Physical Address:	
Mailing Address:	
Phone Number:	

PART V Limited Permit History

I have previously held a limited permit in Alaska on: Month: _____ Year: _____

Mail my limited permit to the address I provided on the first page.

Mail my limited permit to this address:

Address: _____

City: _____

State: _____

ZIP: _____

PART VI Professional Credentials (License held in other jurisdictions)

Chronologically list every state, U.S. jurisdiction, or country where you currently hold, or have ever held, a physical therapist, physical therapy assistant, occupational therapist, or occupational therapy assistant license or permit.

State or Country	License Number	Original Issue Date	Expiration Date
		Month ____ Day ____ Year ____	Month ____ Day ____ Year ____
		Month ____ Day ____ Year ____	Month ____ Day ____ Year ____
		Month ____ Day ____ Year ____	Month ____ Day ____ Year ____
		Month ____ Day ____ Year ____	Month ____ Day ____ Year ____
		Month ____ Day ____ Year ____	Month ____ Day ____ Year ____
		Month ____ Day ____ Year ____	Month ____ Day ____ Year ____
		Month ____ Day ____ Year ____	Month ____ Day ____ Year ____
		Month ____ Day ____ Year ____	Month ____ Day ____ Year ____

PART VII Professional Employment History

Beginning with your current PT/PTA or OT/OTA 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 in time from practice of more than 120 days duration. If practice began prior to permanent licensure, provide permit number and date issued. Make additional copies if necessary.

Facility Name:			
Facility Address:			
Dates of Practice:	From: Month ____ Year ____	To: Month ____ Year ____	
Date of Original License or Permit:	Month ____ Day ____ Year ____	Issuing State	
Any Additional Comments:			

Facility Name:			
Facility Address:			
Dates of Practice:	From: Month ____ Year ____	To: Month ____ Year ____	
Date of Original License or Permit:	Month ____ Day ____ Year ____	Issuing State	
Any Additional Comments:			

Facility Name:			
Facility Address:			
Dates of Practice:	From: Month ____ Year ____	To: Month ____ Year ____	
Date of Original License or Permit:	Month ____ Day ____ Year ____	Issuing State	
Any Additional Comments:			

Facility Name:			
Facility Address:			
Dates of Practice:	From: Month ____ Year ____	To: Month ____ Year ____	
Date of Original License or Permit:	Month ____ Day ____ Year ____	Issuing State	
Any Additional Comments:			

Facility Name:			
Facility Address:			
Dates of Practice:	From: Month ____ Year ____	To: Month ____ Year ____	
Date of Original License or Permit:	Month ____ Day ____ Year ____	Issuing State	
Any Additional Comments:			

Facility Name:			
Facility Address:			
Dates of Practice:	From: Month ____ Year ____	To: Month ____ Year ____	
Date of Original License or Permit:	Month ____ Day ____ Year ____	Issuing State	
Any Additional Comments:			

Facility Name:			
Facility Address:			
Dates of Practice:	From: Month ____ Year ____	To: Month ____ Year ____	
Date of Original License or Permit:	Month ____ Day ____ Year ____	Issuing State	
Any Additional Comments:			

PART VIII Professional Background

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. Provide your explanation on a separate sheet of paper labeled with your name, and signed by you; include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. Documentation includes copies of court orders, charging documents, closing documents, board or license actions, etc. When in doubt about your response, disclose and provide the required explanation and documents.

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "Yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

WHEN IN DOUBT, DISCLOSE AND EXPLAIN

- | | | | |
|----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-----------------------------|
| 1. | Have you ever been disciplined by any state board or Physical/Occupational Therapy Association concerning violation of the Physical/Occupational Therapy Practice Act or unethical conduct? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 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 <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. | Have you ever been denied the privilege of taking an examination before any state Physical/Occupational Therapy Board? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 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 <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. | Have you ever been convicted of a violation of any federal or state narcotic laws? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6. | Have you ever had any malpractice settlements or judgments paid on your behalf? | Yes <input type="checkbox"/> | No <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? | * Yes <input type="checkbox"/> | No <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? | * Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 9. | Do you have a physical disability which could affect your ability to practice physical or occupational therapy? | * Yes <input type="checkbox"/> | No <input type="checkbox"/> |

*	<p>If you checked "Yes" to any of the above questions, you must attach a signed and dated detailed explanation.</p> <p>If you checked "Yes" to questions 7, 8 or 9, in addition to your personal statement, you must request a "fit to practice" letter from the appropriate health care provider indicating your ability to practice.</p>
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PART IX Notarized Signature

I certify that the information on this form is true and correct to the best of my knowledge and that all credentials supplied by me to support my application are true and correct. The Division may deny, suspend, or revoke the license of a person who has obtained or has attempted to obtain a license by fraud or deceit. The person may also be subjected to criminal charges for perjury or unsworn falsification. (AS 11.56.210)

Notary Stamp	Applicant's Signature:		Printed Name:	
	Notary Public for State of:		Subscribed and Sworn to Before me on this Day:	
	Notary's Signature:		My Commission Expires:	



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Authorization for Release of Records

I hereby authorize the Alaska Division of Corporations, Business and Professional Licensing and its investigators to examine my medical, dental, employment, educational 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 treatments. This release specifically includes information from federal service and peer review organizations.

I request that upon presentation of this release, or a certified true copy, that you provide copies of those records to the division and 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 Alaska physical therapy licensure. This authorization expires one year from the date of my signature.

I hereby release you, your organization, the Alaska Department of Commerce, Community, and Economic Development, Division of Corporations, Business and Professional Licensing, and its investigators, and all others directly or indirectly involved in this matter from any liability or damage which may result from furnishing the information requested.

Name			
Address			
Phone		Date of Birth	
Email			
Signature		Date	



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Limited Permit Statement

Full Name:	
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Applying For:	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Physical Therapy Assistant
	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Occupational Therapy Assistant

Alaska Employer's Name:	
Alaska Employer's Address:	
Date Employment Begins:	
Date Employment Ends:	

- I am a visiting, nonresident, and will not work in the State of Alaska for more than 120 days in this calendar year.
- I understand I can only have three limited permits in my lifetime and that I can only have one limited permit in a calendar year. If this permit is issued after September 3, I understand that the permit ends at 11:59 p.m. on December 31st.

Signature:	Date:

Note: If you have not yet secured employment you may mail this form to our office at a later date. This will allow the application process to proceed to the point where this is the final required document you need to submit to obtain the limited permit.



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Verification of Licensure — Physical or Occupational Therapy

→ **Applicant:**

Complete this top part and then forward it to the licensing boards in every jurisdiction where you are, or have been, licensed. Make copies as needed.

Some states require a fee for completion of license verification; check with the state boards prior to submitting this form to them.

Full Legal Name:		Email:	
Mailing Address:			
Applicant's Signature:		Date:	

→ **State Board:**

Complete this bottom part for the applicant identified above and return the form directly to the letterhead address. You may use your state verification of license certificate if it includes all of the below information. Electronic VOLs are accepted.

Licensing Jurisdiction:		License Number:	
Name of Licensee:		Periods of Lapse:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Licensed By:	<input type="checkbox"/> Credentials <input type="checkbox"/> Reciprocity <input type="checkbox"/> Other: _____ <input type="checkbox"/> Examination: which examination did the licensee pass? _____		
Initial License Date:		Expiration Date:	

- Has the license ever been revoked, suspended, placed on probation, or restricted in any way? If yes, please enclose an explanation or documentation. Yes No
- 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 you answer "Yes" to any question above, please attach a detailed explanation or documentation signed and dated by the person whose signature appears below.

Board Seal	Signature:	Date:
	Printed Name	Title
	Phone	Email



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CREDIT CARD PAYMENT

For security purposes please do not email credit card information. Fax or mail this credit card payment form to the Division. Completion of this form is not proof of payment until the Division processes the information. If any information on this form is illegible, the form will be rejected.

Name of Applicant or Licensee: _____

Type of License: _____ License Number (if applicable): _____

Table with 2 columns: Description and Amount. Rows include Application Fee, License or Renewal Fee, Other (name change, wall certificate, fine, duplicate license, exam, etc.), and Total.

Name (as shown on credit card): _____

Mailing Address: _____

Phone: _____ Email (optional): _____

Credit Card Type: [] VISA — or — [] Mastercard

Signature of Credit Card Holder: _____

.....

VISA or Mastercard Number: _____ Expiration Date: _____

This section below the dotted line will be destroyed upon processing of the payment.