



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
665 Mainstream Drive, 2<sup>nd</sup> Floor  
NASHVILLE, TENNESSEE 37243

**TENNESSEE BOARD OF PHYSICAL THERAPY**  
1-800-778-4123 EXT., 7413807 or Locally (615) 741-3807  
<http://tennessee.gov/health/topic/PT-board>

**APPLICATION INSTRUCTIONS FOR LICENSURE AS A PHYSICAL THERAPIST  
AND PHYSICAL THERAPIST ASSISTANT  
LICENSURE APPLICATION CHECK SHEET**

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee license to practice physical therapy. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Board.**

1. All pages of the application must be returned.	
2. Tape (not staple) a recent, 2X2 <b>only</b> full-faced, passport type photograph to the first page of the application. Computer generated images are not acceptable.	
3. Determine the correct amount of fees to be paid according to the fee schedule (page 12 and 13). Attach check or money order for the proper amount made payable to the <b>State of Tennessee</b> .	
4. All applicants must submit an original ( <b>signed and dated</b> ) letter of recommendation attesting to their good moral character. This letter must be from a Physical Therapist or Physical Therapist Assistant licensed in the U.S. ( <b>This letter cannot be from a relative.</b> )	
5. You must have your scores reported by the FSBPT Score Transfer Service if you have previously passed the National Physical Therapy Examination by Tennessee standards. Exams taken prior to July 12, 1995, will be based on the norm referenced scoring method. All exams taken July 12, 1995 and after, will be based on the criterion referenced scoring method. Please visit <a href="http://www.fsbpt.org">www.fsbpt.org</a> to order the score transfer or call 703-299-3100.	
6. You must request your school to send official transcripts that show degree and date conferred before permanent licensure can be granted. Transcripts must come directly from the school to the Board's Administrative Office, reference the name under which you are applying for licensure, and must carry the official seal of the institution. If you are not sure if your school's PT/PTA Program is CAPTE-accredited, contact the school or the American Physical Therapy Association (APTA) for this information. You may want to contact your school to see if there is a fee for this process. If you have <b>completed</b> all the requirements for your degree and your diploma or transcripts are not available, you can have the Program Director of the school send a letter of verification that all requirements for your degree have been completed. This will enable you to be deemed eligible for the exam.	

<p>7. If you are or have ever been licensed, certified, registered, or permitted by any state to practice as a physical therapist or physical therapist assistant (or any other profession), you must request a verification from each and every state. Each state must submit the verification of certification, licensure or permit directly to Tennessee. You may want to contact the other licensing board(s) to see if there is a fee for this process.</p>	
<p>8. Documentation submitted to the Board by International graduates that is not written in English must have an English translation. The English translation of the documents must be certified.</p>	
<p>9. International Graduates (even if you are licensed in another state in the U.S.) must have a “Comprehensive Credential Evaluation Certificate for the TN Physical Therapist” from the Foreign Credentialing Commission on Physical Therapy (FCCPT) or a comparable evaluation and documentation from the International Consultants of Delaware (ICD), submitted directly to the Board from the FCCPT (a Type 1 Certificate) or ICD (comparable to the Type 1 Certificate from the FCCPT), before applying for licensure in TN as a Physical Therapist or Physical Therapist Assistant.</p> <p style="text-align: center;"> FCCPT  124 West Street South, Third Floor  Alexandria, VA 22314  (703) 684-8406  <a href="http://www.fccpt.org">www.fccpt.org</a> </p> <p style="text-align: center;"> ICD  PO Box 8629  Philadelphia, PA 19101-8629  (215) 222-8454 ext 603  <a href="http://www.icdeval.com">www.icdeval.com</a> </p> <p>Please note that all International Educated applicants will be required to complete a 480 hour Supervised Clinical Practice (in TN) after educational credentials have been approved by the Board.</p>	
<p>10. All exam applicants can register to take the exam at <a href="http://www.fsbpt.org">www.fsbpt.org</a>. International Educated applicants should not register for the exam until after the Board’s approval of educational credentials.</p>	
<p>11. If you are applying for a license as a Physical Therapist you must complete and return the “Mandatory Practitioner Profile” with your application before a license can be granted. For instructions, go to (<a href="http://tn.gov/assets/entities/health/attachments/PH-3585.pdf">http://tn.gov/assets/entities/health/attachments/PH-3585.pdf</a>)</p>	
<p>12. If you wish to obtain certification to perform EMG’s please refer to Rule 1150-1-.04(4) for requirements.</p>	
<p>13. Please submit a Criminal Background Check. To obtain instructions for a criminal background check, go to (<a href="http://www.tn.gov/health/topic/CBC-check">http://www.tn.gov/health/topic/CBC-check</a>)</p>	
<p>14. All applicants must complete, sign and have notarized the Declaration of Citizenship form and attach the documents required by the Declaration of Citizenship. The Declaration is online at <a href="http://tn.gov/assets/entities/health/attachments/PH-4183.pdf">http://tn.gov/assets/entities/health/attachments/PH-4183.pdf</a> and must be attached to this application before submission.</p>	

## UNDERSTANDING THE APPLICATION PROCESS

If an address change occurs at any time, you must notify the Board office, in writing, immediately.

1. Please submit application fees by certified or personal check, or money order made payable to the State of Tennessee. **ALL APPLICATION FEES ARE NON-REFUNDABLE.**
2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

Board of Physical Therapy  
665 Mainstream Drive, 2<sup>nd</sup> Floor  
Nashville, TN 37243

For Federal Express or Special Courier:  
Board of Physical Therapy  
665 Mainstream Drive, 2<sup>nd</sup> Floor  
Nashville, TN 37228

3. **Allow fourteen (14) working days for information mailed to our office to be received and placed in your file.** Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you will be responsible for charges incurred. The Board asks that you please give the Board office every consideration in this matter.
4. **We will discuss application status with the applicant, applicant's spouse or to whomever may hold power of attorney only.** Please inform hospitals, employers, recruiters, referral companies or insurance companies that application status updates must be obtained from the applicant only. Status information will be mailed to the address listed on the application.
5. An initial deficiency letter will be sent to you by certified mail to notify you of documentation not received to complete your application process by the Board office,
6. **Absent any complicating factors, the average application processing time is six weeks. Once the application is completed, your file will be promptly reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination.**
7. If you are taking an exam in Tennessee the average time for receipt of scores from the FSBPT is three to four days. An additional week (1) is required by our office for processing. Exam information (i.e. scores, pass, fail) **will not** be given over the phone.
8. It is recommended that you **do not** make arrangements to accept employment as a Physical Therapy or a Physical Therapist Assistant Practitioner in Tennessee until you are granted a license by the Tennessee Board of Physical Therapy.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.

**IMPORTANT: You must have a Tennessee License from the Board in your possession before you may lawfully practice as either a Physical Therapist or Physical Therapist Assistant.**

You **must** put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code Ann. §36-5-1301(a), as authorized by 42 U.S.C. §405 (c) (2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that the Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

ATTACH A  
CURRENT  
FULL-FACE 2X2  
PHOTOGRAPH



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<b>FOR OFFICIAL USE ONLY</b>		
Attach to this application a check or money order payable in U.S. funds to the Tennessee Board of Physical Therapy.		
<b>Initial</b>	2109-001	\$ <u>125</u>
	2109-006	\$ <u>10</u>
<b>Reciprocity</b>	2109-001	\$ <u>225</u>
	2109-006	\$ <u>10</u>
<b>Initial</b>	2125-001	\$ <u>115</u>
	2125-006	\$ <u>10</u>
<b>Reciprocity</b>	2125-001	\$ <u>215</u>
	2125-006	\$ <u>10</u>

**PHYSICAL THERAPIST AND PHYSICAL THERAPIST ASSISTANT LICENSURE APPLICATION**

Choose the appropriate licensure category and method for which you are applying. See the Practice Act and the Rules and Regulations to determine the requirements for each category of practitioner.

**LICENSURE ALTERNATIVES**

<p>A. _____ Physical Therapist License</p> <p>_____ Reciprocity from another state</p> <p>_____ Examination</p>	<p>B. _____ Physical Therapist Assistant License</p> <p>_____ Reciprocity from another state</p> <p>_____ Examination</p>
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**PERSONAL INFORMATION**

Name: \_\_\_\_\_  
Last First Middle Maiden (if not used as your middle name)

Social Security Number: \_\_\_\_\_ U.S. Citizen: Yes \_\_\_ No \_\_\_  
All applicants must complete the Declaration of Citizenship form

Date of Birth: \_\_\_\_\_ Entitled to Live and Work in the U.S. Yes \_\_\_ No \_\_\_

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

Practice Address: \_\_\_\_\_  
 \_\_\_\_\_ Zip \_\_\_\_\_

E-mail address: \_\_\_\_\_

Do you wish to receive notifications, including renewal notification, from Department of Health via email? Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office. \_\_\_ Yes \_\_\_ No

Race: \_\_\_\_\_ Phone: Home: \_\_\_\_\_  
 Gender: Female \_\_\_ Male \_\_\_ Office: \_\_\_\_\_

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? (If yes, please provide proof of status.) Yes \_\_\_ No \_\_\_

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.) Yes \_\_\_ No \_\_\_

Have you ever been known by any other names besides what is listed above? Yes \_\_\_ No \_\_\_

If yes, please state in full every other name by which you have been known, the reason therefore, and inclusive dates so known: \_\_\_\_\_

**EDUCATIONAL AND EMPLOYMENT INFORMATION**

Please provide the following information for your attendance in college. Use the back of this page if you need additional space. Request that transcripts be sent directly to the Board's Office from your school.

From: \_\_\_\_\_  
 MM/DD/YY MM/DD/YY Educational Institution Location

**Please complete your entire healthcare employment history starting with the most current position first.** Use the back of this page, if you need additional space. Dates of employment must be included.

<u>Company/ Employer:</u>	<u>Address: (City, and State)</u>	<u>Position:</u>	<u>Duties:</u>	<u>Dates</u>	
				<u>From: Mo./Yr.</u>	<u>To: Mo./Yr.</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**CERTIFICATION INFORMATION**

Are you or have you ever been licensed in this profession in another state? YES NO  
\_\_\_\_\_

Are you or have you ever been licensed in any other profession in Tennessee or another state? \_\_\_\_\_

List below **ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED, PERMITTED, OR CERTIFIED.** Additional pages may be added if necessary. Request that verification of licensure be submitted directly to the Board's Office from each state.

STATE	PROFESSION	LICENSE NUMBER	CURRENT STATUS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- |  | YES   | NO    |
|--|-------|-------|
| 1. Have you ever applied for a Physical Therapy license in Tennessee?<br>Check one: ( ) Assistant ( ) Therapist  | _____ | _____ |
| 2. Have you ever taken the PES or ASI National Physical Therapy Examination (NPTE)<br>Check one ( ) Assistant ( ) Therapist<br><br>If yes, please give dates on which the exam was taken _____ | _____ | _____ |
| 3. Are you currently scheduled to take the PES NPTE in any other state?<br><br>If yes, please list state in which you are scheduled to take the NPTE _____                                     | _____ | _____ |
| 4. Have you ever failed the NPTE? If yes, how many times _____   | _____ | _____ |

**COMPETENCY INFORMATION**

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer "yes" to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. IN SUPPORT OF YOUR EXPLANATION, THE FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, AND/OR AGENCIES MUST BE SUBMITTED ALONG WITH THIS APPLICATION. Additional information may be requested and/or required before a licensure decision may be made. For the purposes of these questions, the following phrases or words have the following meanings:

- 1. **"Ability to practice your profession"** is to be construed to include all of the following:
  - a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments in your profession;
  - b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
  - c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
- 2. **"Medical Condition"** includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.
- 3. **"Minor Traffic Offense"** generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.
- 4. **"Chemical substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
- 5. **"Currently"** does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.
- 6. **"Illegal use of illicit or controlled substances"** means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

**QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.**

**YES NO**

- 1. Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice? \_\_\_\_\_
- 2. Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety? \_\_\_\_\_

If so, please list: \_\_\_\_\_

*[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, conditions should be imposed, or you are not eligible for licensure.]*

**COMPETENCY INFORMATION CONTINUED**

<b>QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.</b>		<b>YES</b>	<b>NO</b>
3.	At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?	___	___
4.	Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances?	___	___
5.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature?	___	___
6.	Have you ever held or applied for a license, privilege, registration or certificate to practice your profession in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	___	___
7.	Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	___	___
8.	Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?	___	___
9.	Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?	___	___
10.	Have you ever been rejected or censured by a professional association or society?	___	___
11.	In relation to the performance of your professional services in any profession:		
	a. Have you ever had a final judgment rendered against you;	___	___
	b. Have you ever entered into any settlement of any legal action; or	___	___
	c. Are there any legal actions pending against you or to which you are a party?	___	___
12.	Have you ever held a license, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction?	___	___
13.	My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state)	___	___

**APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT**

**AFFIDAVIT AND RELEASE**

I, \_\_\_\_\_, of \_\_\_\_\_,  
(Applicant's Name) (City) (State)

being duly sworn and identified as the person referred to in this application attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice of my profession in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice in my profession.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications, for certification.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

This certifies that the information submitted by me in this application is true and complete to the best of my knowledge and belief.

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**



## FEE SCHEDULE FOR THE BOARD OF PHYSICAL THERAPY

### PHYSICAL THERAPIST

PT	By examination: (Total fee due \$ 135.00)	
\$100.00	APPLICATION FEE	09-001
\$ 25.00	LICENSE FEE	09-001
\$ 10.00	STATE REGULATORY FEE	09-006

PT	By Reciprocity: (Total fee due \$ 235.00)	
\$ 100.00	APPLICATION FEE	09-001
\$ 100.00	RECIPROCITY FEE	09-001
\$ 25.00	LICENSE FEE	09-001
\$ 10.00	STATE REGULATORY FEE	09-006

### PHYSICAL THERAPIST ASSISTANT

PTA	By examination: (Total fee due \$ 125.00)	
\$ 90.00	APPLICATION FEE	25-001
\$ 25.00	LICENSE FEE	25-001
\$ 10.00	STATE REGULATORY FEE	25-006

PTA	By Reciprocity: (Total fee due \$225.00)	
\$ 90.00	APPLICATION FEE	25-001
\$100.00	RECIPROCITY FEE	25-001
\$ 25.00	LICENSE FEE	25-001
\$ 10.00	STATE REGULATORY FEE	25-006

ATTACH CHECK OR MONEY ORDER PAYABLE TO **STATE OF TENNESSEE**.