FORM 3

(check one)

☐ **Physical Therapist**

☐ **Phys Therapist Asst.**

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

CERTIFICATION OF PHYSICAL THERAPIST OR PHYSICAL THERAPIST ASSISTANT LICENSURE IN ANOTHER STATE

APPLICANT INSTRUCTIONS

If you are not licensed in another State or U.S. territory, do NOT use this form. You must use CGFNS or FCCPT to verify your licensure status.

1. Complete Section 1. Enter your name as it appears on your Application (Form 1). Be sure to sign and date item 7.
2. Send this form with any fee required to the appropriate licensing authority of the state in which you are or have been licensed to complete Section II and return this form directly to the Office of the Professions at the address at the end of this form.

NOTE: A separate Form 3 must be received by the Department from every state in which you are or have been licensed.

SECTION I: APPLICANT INFORMATION

1 SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐

(Leave this blank if you do not have a U.S. Social Security Number)

2 BIRTH DATE ☐☐ ☐☐ ☐☐

Month Day Year

3 PRINT FULL NAME

Last ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

First ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Middle ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

4 MAILING ADDRESS

Street ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

State ☐☐ Zip Code ☐☐☐☐☐ ☐☐☐☐

Province/Country If not U.S. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

5 If you took a licensing examination in the United States using a different name, enter that name below:

Last _____ *First* _____ *Middle* _____

6 If licensed by examination in the United States, indicate state or territory: _____

Date license was issued: _____ / _____ / _____ License number: _____

7 I request and give my permission to the licensing authority listed in item 6 above to complete the information on this form and mail it to the New York State Education Department and to release any other information required by the State Education Department in connection with my application for licensure.

Applicant's signature: _____ Date: _____ / _____ / _____
mo. day yr.

SECTION II : CERTIFICATION OF LICENSURE

INSTRUCTIONS TO LICENSING AUTHORITY: Please complete this section and return this form **directly** to the Office of the Professions at the address at the end of this form. This form will not be accepted if returned by the applicant. Attach additional sheets if necessary.

1. Name of applicant: _____

2. Profession in which applicant is licensed in your jurisdiction: ☐ Physical Therapy ☐ Physical Therapist Assistant

3. License number: _____ Date of licensure: _____ / _____ / _____
   Mo. Day Yr.

4. Jurisdiction issuing original license or certification: _____

5. Is the individual currently licensed or registered? ☐ Yes ☐ No If Yes, Date of expiration: _____ / _____ / _____
   Mo. Day Yr.

6. Please indicate if the license was issued under any of the following special conditions (check all that apply):
   - ☐ Endorsement of licensure in another jurisdiction (please identify: _____)
   - ☐ Waiver of examination
   - ☐ Waiver of education
   - ☐ Other (please attach explanation)

7. If the license was issued based on an examination, please indicate the examination title, date and score (eg. National Physical Therapy Examination; PES/ASI Examination; State Examination, etc.):

   Examination title _____ Date _____ / _____ / _____ Score _____

8. Did the issuance of this license involve any practice limitations? ☐ Yes ☐ No

9. Was there ever any disciplinary action against this license? ☐ Yes ☐ No
   (If the answer to question 5 or 6 is yes, please describe in detail and attach.)

10. Are there any disciplinary charges pending against this license or has he/she surrendered a license to avoid disciplinary charges? ☐ Yes ☐ No

CERTIFICATION

I certify that to the best of my knowledge and belief the foregoing is a true statement of the record of the applicant named on this form. I further certify that, other than those listed above or attached, this licensing authority has never taken any disciplinary action against this person and that, in so far as the licensing authority has knowledge, there have been no charges preferred nor has any information been presented relating to any question of unprofessional or immoral conduct .

Signature _____ Date _____ / _____ / _____

Title _____

Agency _____

Address _____

_____

Telephone number _____ Fax _____

E-mail _____

(LICENSING AUTHORITY SEAL)

RETURN DIRECTLY TO →	New York State Education Department, Office of the Professions, Division of Professional Licensing Services, **Physical Therapy Unit**, 89 Washington Avenue, Albany, New York 12234-1000