

REGISTRATION REMITTANCE ADDENDUM

Physical Therapist 62 Physical Therapist Assistant 66

Continuing Education: Every physical therapist and physical therapist assistant registered to practice in New York State must complete approved continuing education for each triennial registration period. The required number of hours is calculated at the rate of 0.5 hours per month from January 1, 2010 through September 1, 2012. Thereafter, the required number of hours is calculated at the rate of 1.0 hours per month. Physical therapists and physical therapist assistants are exempt from the requirement for the first three (3) years following **initial** licensure. Each licensee must maintain documentation of completion of required coursework for a period of six (6) years and be subject to audit by the New York State Education Department. Do not send any continuing education documents with this application unless requested to do so. For more information, please visit our Web site www.op.nysed.gov/pt.htm.

The following instructions are **ONLY** for those individuals who have **NOT** met the continuing education requirement.

Individuals who have **NOT** met the continuing education requirement **MUST** choose one of the following options and return this form with their Registration Remittance Document and fee (if required). Your signature indicates agreement with the terms of the option you have selected.

1. I do not intend to practice in New York State during the period indicated on the Registration Remittance Document, and am requesting that my registration be placed in an **INACTIVE STATUS**.

As long as your registration remains inactive, you are not responsible for either the registration fee or the continuing education requirement until such time as you intend to resume practicing in New York State. At that time, you must meet certain continuing education requirements **prior to reactivating your registration**. You may not practice as a physical therapist or physical therapist assistant in New York State if you are not registered.

Name (please print) _____ License number _____

Signature _____ Date ____ / ____ / ____

Home telephone number _____ Work telephone number _____

Fax number _____ E-mail address _____

2. I request a **CONDITIONAL REGISTRATION**.

Conditional registrations are not automatic and may be issued at the Department's discretion. A conditional registration, if granted, is valid for one year and cannot be renewed or extended. You may request a conditional registration for a one-year period if you agree to:

- pay the full registration fee for the one-year conditional registration;
- complete the continuing education hours you are lacking from your previous registration registration period;
- complete the regular continuing education requirement prorated for the one-year conditional registration period, and, at the end of the conditional registration period,
- provide proof of completion of the continuing education requirement and pay the registration fee for the remaining two years of your registration when the conditional registration expires.

Prior to the end of the one-year conditional registration period, you will be sent a Registration Remittance Document that you must complete and submit with the fee and proof of completion of the requirements before you will receive a registration for the remaining two years. **Failure to meet the requirements of the conditional registration may subject you to prosecution for professional misconduct.**

Name (please print) _____ License number _____

Signature _____ Date ____ / ____ / ____

Home telephone number _____ Work telephone number _____

Fax number _____ E-mail address _____

3. I request an **ADJUSTMENT** to the continuing education requirements for registration.

Adjustments to the continuing education requirement may be granted by the Department for reasons of health documented by an appropriate health care professional, extended active duty with the armed forces of the United States, or other good cause. A written explanation (from health care professional, if applicable) documenting the circumstances which prevented compliance with Education Law must be included with this form.

Name (please print) _____ License number _____

Signature _____ Date ____ / ____ / ____

Home telephone number _____ Work telephone number _____

Fax number _____ E-mail address _____

If you have not met the continuing education requirement, either:

- **mail this form with your registration remittance document and appropriate fee (if required) in the envelope provided; or**
- **complete your request online at www.op.nysed.gov/renewalinfo.htm**

Please make a copy of this form and retain it for your records.

If you need additional information, please contact:

State Board for Physical Therapy
New York State Education Department
89 Washington Avenue, Second Floor East Wing
Albany, New York, 12234-1000

Telephone: 518-474-3817 ext. 180

Fax: 518-402-5944

E-mail: ptbd@mail.nysed.gov