MINNESOTA
BOARD OF PHYSICAL THERAPY

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MN Relay Service for Hearing Impaired 800.627.3539 (phone)

APPLICATION TO PRACTICE PHYSICAL THERAPY

1. Review Application Instructions form (**Separate** document located on Board's website under "Applicants").
2. Review Criminal Background Check Information (**Separate** document located on Board's website under "Applicants").
3. Answer all application questions completely, accurately, and legibly **or the application will be returned**.
4. The name you enter must be your full legal name.
5. All addresses must include zip code if requested on the application.
6. Account for all time **from the beginning of high school**, whether spent in school, physical therapy practice, or otherwise.
7. All dates must be in **Month/Year format** unless otherwise specified.
8. **All fees are non refundable.**
9. Failure to answer all questions completely and accurately, and/or an omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.
10. **Attach additional sheets if necessary.**
11. Review check list to assure application is complete prior to submission (Page 7 of the application)
12. Immediately inform the Board of any changes in application information.

Application Date

_____
(Month/Day/Year)

To the Minnesota Board of Physical Therapy:

I hereby make application for a license to practice physical therapy in the State of Minnesota and submit the following statement concerning my birth, moral character, preliminary and professional education and practice.

YOUR CURRENT NAME AND ADDRESS

Full Legal Name (Last, First, Middle)		Previous Name, if changed	Gender
Street Address			
City	State or Province	Zip Code	Country
Primary Phone	Secondary Phone (optional)	Email (optional)	
Social Security or Alien Registration Number		Driver's License (State and License Number)	

BASIS FOR APPLICATION (check one)

☐ NPTE Exam (New graduate)

☐ NPTE/ASI/PES Exam
(U.S. Educated PT Licensed in Another State)

☐ Foreign Educated PT

FOR BOARD USE ONLY

Date Received: _____ Check #: _____

Amount Paid: _____ Deposit #: _____

641900 PT Application: _____ 641901 PT License: _____

641902 Exam: _____ 641903 PT - TP: _____

641917 CBC: _____ Returned (Incomplete/Incorrect Fees/Other)

APPLICANT'S RECORD OF BIRTH

Date of Birth (Month/Day/Year)	City of Birth	State of Birth	Country of Birth

APPLICANT'S IDENTIFYING CHARACTERISTICS

Height	Weight	Color of Hair	Color of Eyes
Identifying Marks (**If none, state "None**")			

ADDRESS OF NEAREST RELATIVE

Name	Street Address	
City, State or Province, & Zip Code	Country	Relationship

PRELIMINARY EDUCATION

Name of High School	City	State/Province	From (Month/Year)	To (Month/Year)	Type of Degree
Name of College/University	City	State/Province	From (Month/Year)	To (Month/Year)	Type of Degree
Name of College/University	City	State/Province	From (Month/Year)	To (Month/Year)	Type of Degree
Name of College/University	City	State/Province	From (Month/Year)	To (Month/Year)	Type of Degree

PHYSICAL THERAPY EDUCATION

Name of College/University	City	State/Province	From (Month/Year)	To (Month/Year)
Type of Degree Received ☐ Certificate ☐ B.S. ☐ M.P.T. ☐ D.P.T.			**Date Received (Month/Day/Year)**	

STATES/PROVINCES/COUNTRIES IN WHICH YOU ARE OR HAVE BEEN LICENSED OR REGISTERED

State/Province/Country	License or Registration #	Original Issue Date	Expiration Date

MEMBERSHIP IN PROFESSIONAL SOCIETIES AND ORGANIZATIONS

Professional Society or Organization	From (Year)	To (Year)

MILITARY SERVICE

Branch of Service	Date of Entry (Month/Year)	Date of Release (Month/Year)	Rank at Discharge	Type of Discharge
Duty Assignment		Location		

PRACTICE LOCATIONS and REFERENCES

List below where you have practiced, and provide two references from each facility, preferably two licensed physical therapists.

For New Graduates: Please list all of your clinical affiliations and include 2 references for each location.
For US Educated PTs Licensed in Another State and for **Foreign Educated PT** applicants**:** Please document all of your professional PT practice locations since graduating from PT school & include 2 references for each location**. Attach additional sheet(s) if needed.**

Facility Name, Address, & Phone Number		From (Month/Year)	To (Month/Year)
Reference Name	Reference Address	Reference Phone Number	
Reference Name	Reference Address	Reference Phone Number	

Facility Name, Address, & Phone Number		From (Month/Year)	To (Month/Year)
Reference Name	Reference Address	Reference Phone Number	
Reference Name	Reference Address	Reference Phone Number	

Facility Name, Address, & Phone Number		From (Month/Year)	To (Month/Year)
Reference Name	Reference Address	Reference Phone Number	
Reference Name	Reference Address	Reference Phone Number	

Facility Name, Address, & Phone Number		From (Month/Year)	To (Month/Year)
Reference Name	Reference Address	Reference Phone Number	
Reference Name	Reference Address	Reference Phone Number	

Facility Name, Address, & Phone Number		From (Month/Year)	To (Month/Year)
Reference Name	Reference Address	Reference Phone Number	
Reference Name	Reference Address	Reference Phone Number	

ACCOUNTING OF TIME (SINCE HIGH SCHOOL) NOT NOTED ELSEWHERE ON THIS APPLICATION

Activities/employment, city and state (Attach separate sheet, if necessary)	From (Month/Year)	To (Month/Year)

ACCOUNTING OF REQUIRED DATA

Mark Yes or No. Attach additional sheets to provide sufficient detail. For questions 1 and 2 below, the terms "impaired" and "limited" include but are not limited to impairments or limitation related to physical, psychological, or emotional disorders or conditions, or chemical dependency or chemical abuse. **If responses to questions change during the time your application is pending, you must make the Board aware of the new information.**

1. Is your cognitive, communicative, or physical ability to engage in practice as a physical therapist with reasonable skill and safety been impaired or limited in any way? Please describe on a separate sheet. **Yes No**

1a. If "Yes", are the limitations or impairments reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Please describe on a separate sheet.	**Yes No**
1b. If "Yes", are the limitations or impairments reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? Please describe on a separate sheet.	**Yes No**

2. Does your use of alcohol or chemical substances(s), including prescription medications, in any way impair or limit your ability to practice as a physical therapist with reasonable skill and safety? Please describe on a separate sheet. **Yes No**

3. Are you engaged in any illegal use of controlled substances including use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a licensed health care provider). Please describe on a separate sheet. **Yes No**

3a. If "Yes", have you taken any steps (i.e. treatment, psychotherapy, participation in a support group) to discontinue or reduce such use? Please describe on a separate sheet.	**Yes No**
3b. If "Yes", are you now participating in a supervised rehabilitation program or professional assistance program which has as a component a monitoring regimen designed to assure that you are not currently engaging in the use of illegal controlled substances? Please describe on a separate sheet.	**Yes No**

4. Have you within the past five years been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice as a physical therapist with reasonable skill and safety? **Yes No**

If you answered this question "Yes", please answer the following:

4a. With regard to any condition referenced above, are you being treated so that such impairment is avoided?	**Yes No**
4b. With regard to any condition referenced above, are you in compliance with the recommended treatment?	**Yes No**
4c. With regard to any condition referenced above, has your treating physician advised you that you are able to practice as a physical therapist with reasonable skill and safety?	**Yes No**
4d. Please explain on a separate sheet.	
4e. Identify your treating physician:	

5. Have you ever been diagnosed as having or have you been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders? If so, please describe on a separate sheet. **Yes** **No**

6. Have you ever been the subject of an investigation by any Federal, State, or Local agency having jurisdiction over controlled substances? If so, give particulars on a separate sheet. **Yes** **No**

7. Have you ever been denied licensure/registration by, or the privilege of taking an examination before any examining board, or has a conditioned license/registration ever been issued to you by any state board or other licensing authority? If so, give particulars on a separate sheet. **Yes** **No**

8. Has your license/registration to practice as a physical therapist in any state or country ever been voluntarily or involuntarily (i.e. by State Board Order or any other form of disciplinary action) revoked, suspended, restricted, or conditioned by a State Board or other licensing authority? If so, give particulars on a separate sheet. **Yes** **No**

9. Have you ever been notified of any investigations by any state board, physical therapy society, certifying authority or any health facility of any complaints against you relative to the practice of physical therapy, or have you been reprimanded or censured by any physical therapy society or licensing board? If so, give particulars on a separate sheet. **Yes** **No**

10. Have you ever been a defendant in any malpractice lawsuits, had any malpractice settlement, or have any pending? If so, give a detailed clinical explanation (on a separate sheet) of each case as well as documentation of outcome (insurance papers or court documents). **Yes** **No**

11. Have you ever been denied, restricted, or revoked staff affiliations with a hospital, nursing home, clinic, or other health care facility? If so, give particulars on a separate sheet. **Yes** **No**

12. Have there been any criminal charges filed against you? This includes adult or juvenile charges of misdemeanor, gross misdemeanor, or felony and any offenses which have been expunged, dismissed or otherwise removed from your record. If so, give particulars including the date of conduct, state or local jurisdiction in which the charges were filed. **Yes** **No**

13. Have there been any charges of Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) or other impaired driving offenses involving alcohol or other chemicals filed against you? If so, give particulars, (on a separate sheet) including the date of conduct, state and local jurisdiction in which the charges were filed. **Yes** **No**

RIGHTS OF SUBJECTS OF DATA

This information is requested by the Minnesota Board of Physical Therapy. The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. The information is classified as private while your application is pending or if your application is denied, and as public if your license is granted. You are required to submit this information. Your application will not be processed without it and the form will be returned to you for completion. This information may be used as the basis for further investigation by the Board into your qualifications. Under some circumstances, the information could become available to other agencies or persons authorized by law to have access. Attach a separate page for detailed explanations, when appropriate. Failure to answer all questions completely and accurately, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.

AFFIDAVIT OF APPLICANT: ***PT***

State (where notarized):_____ County (where notarized): _____

I,_____, swear that I am the person described and identified; that I have not engaged in any of the acts prohibited by the statutes of Minnesota.

I hereby authorize all educational institutions, hospitals, medical institutions or organizations, clinics, my references, personal physicians, employers (past and present), business and professional associates (past and present), all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Board any information, files, or records including (but not limited to) transcripts, medical records, personnel files, and any information, favorable or otherwise, the Board may require for its evaluation of my professional, ethical, and physical qualifications for licensure in Minnesota.

I hereby authorize the Board to verbally and/or in writing, release to and/or exchange with the Federation of State Boards of Physical Therapy (FSBPT), data concerning me which has been classified as "private" under the Minnesota Government Data Practices Act, Minnesota Statutes Section 13.41, subd. 2.

I hereby release, discharge, and exonerate the Board, its agents, and representatives, and any person furnishing information to the Board from any and all liability of every nature and kind arising out of the furnishing of oral information or of documents, records, or other information to the Board.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice physical therapy in Minnesota. I understand that I am required to update my application with pertinent information to cover the time period between date of application and date approved by the Board.

Sworn to before me this_____ day of_____,_____. _____

Signature of **Applicant**

_____

Signature of **Notary Public**

Affix **Notary** Seal or Stamp

Notary Commission Expires:_____

CERTIFICATION OF IDENTIFICATION

Certification of Notary Public is required.

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. Sworn to before me by the applicant on this_____day of_____,_____.

Paste a recent, front-view, passport-type headshot photo in this area.

The Board cannot accept photocopied or scanned images.

_____

Signature of **Notary Public**

Notary Commission Expires: _____

Affix **Notary** Seal or Stamp

_____

Signature of **Applicant**

0315

Faxed or Emailed documents will not be accepted

APPLICATION CHECK LIST

For applicant use, do not submit to the Board

☐ **Page 1:**
- Address complete?
- "Basis for Application" complete?

☐ **Page 2:**
- Write "N/A" (not applicable) in any portion of page 2 that does not apply.

☐ **Page 3:**
- You may use the clinic/facility address and phone number for your practice location references.
- Account for all time since high school (month/year to month/year). There is no need to account for summer breaks during schooling.

☐ **Pages 4 & 5:**
- Are questions 1 – 13 complete?

☐ **Page 6:**
- All required signatures: your name printed at the top and 2 signatures.
- Notarized **twice.**
- **Recent**, full face photograph (**no photocopies please**).

☐ **Application Fees**: Make sure ***ALL*** the required fees are submitted. If the fees that accompany the application are incorrect, the entire application will be returned.

$100.00	Permanent Licensure Application Fee *(required of **ALL** applicants)*
$ 60.00	Annual Licensure Fee *(required of **ALL** applicants)*
$ 32.00	Criminal Background Check Fee *(required of **ALL** applicants)*
$ 50.00	Exam Application Processing Fee ***(only required for new grads and other applicants who need to take the NPTE exam)***
$ 25.00	Temporary permit fee *(optional):* This fee must accompany a completed temporary permit application form. This fee and the temporary permit form may be submitted later during application process.

☐ Read and understand *Rights of Subjects of Data* (pg 5) and *Affidavit of Applicant* (notary required in two areas)(pg 6) .

☐ Review the **application instructions** (which is a separate document located on the MN PT website: http://mn.gov/boards/physical-therapy/ under applicants) specific to the type of application (new grad, PT licensed in another state, or foreign educated PT) and complete the necessary forms.

Applicant notes: