

## Physical Therapist Assistant Instructions (Licensed in Another State)

Please review these materials before submitting your online application. Any processing fees incurred are your responsibility. The Board reserves the right to reject any outdated applications submitted.

**Practice Requirement for Licensure: Applicants licensed in another state who have not practiced 320 hours or achieved a passing score on the NPTE in the past 5 years may choose to retake and pass the exam or complete no less than 320 hours of Board-approved supervised clinical practice.**

**PLEASE NOTE:** Before beginning the online application process, you will need to have the following information available:

- Social Security number or alien registration number or tax ID number
- A record of the applicant's high school, college and board-approved physical therapy school education listing the names, locations, dates of attendance and diplomas, degrees or certificates awarded
- A record of postgraduate work and military service (copy of military discharge papers, if applicable)
- Other licenses or registration numbers, date issued & expiration dates (if applicable)
- Record of all clinicals, include facility name, facility address & phone number with time frame you were there (mm/yyyy to mm/yyyy) and two references (preferably 2 PTs) for each location with address and phone number. You may list the facility's contact information for your references' contact information
- Accounting of time (if applicable) - All time must be accounted for on the application from high school to the date of application. For any time from high school to present that is not accounted for elsewhere on the application, you will need to list your activities/employment, city and state, and date ranges (mm/yyyy-mm/yyyy). During continuous years of education, periods of three months or less (summer break) do not need to be accounted for on the application
- A record of any disciplinary action taken against the applicant by another state board or physical therapy society
- A record of any disease, illness or injury that impairs the applicant's ability to practice physical therapy and record of the applicant's personal use or administration of any controlled substances and treatment for alcohol or drug abuse
- A record of any convictions for crimes related to the practice of physical therapy, felonies, gross misdemeanors, and crimes involving moral turpitude
- Payment for application fees

## Application Fees

Fees are nonrefundable, even if it is determined that you are not eligible for licensure. Fees may be paid via credit card with submission of an online application.

### **Licensure Application Fee: \$100.00 (Required of all applicants)**

This fee must be submitted with your completed online application.

### **Annual Licensure Fee: \$60.00 (Required of all applicants)**

This fee must be submitted with your completed online application.

### **Criminal Background Check Fee: \$32.00 (Required of all applicants)**

This fee must be submitted with your completed online application.

### **Examination Processing Fee: \$50.00 (if applicable)**

Applicants licensed in another state who do not meet the practice requirement may choose to retake and pass the exam. This fee must be paid for each exam attempt. Fees may be paid via check or money order and must be made payable to the MN Board of Physical Therapy.

### **Temporary Permit Fee: \$25.00 (optional)**

A Temporary Permit is available to applicants licensed in another state who meet all the requirements for licensure and wish to practice before the Board grants final approval. Applicants licensed in another state who do not meet the practice requirement may choose to complete no less than 320 hours of Board-approved supervised clinical practice. A Temporary Permit is required for supervised clinical practice and the supervised clinical length, supervisor and site must be pre-approved by the Board. Fees may be paid via check or money order and must be made payable to the MN Board of Physical Therapy.

## Required Application Forms and Documentation

In addition to submitting the online application, there are required forms and documentation that will need to be submitted to the Board, along with completing a fingerprint-based criminal background check. You will not be licensed until your application has been submitted and all requirements for licensure have been met.

Forms and documentation may be mailed to the Board Office prior to submission of your online application and fees. Forms and documentation submitted prior to submission of your online application and fees will be placed in a pending file until your application file is opened. After your online application and fees are received, Board staff will email you when your file has been opened with instructions on how to use your online services account:

<https://phy.hlb.state.mn.us/#/login> to view your application checklist for completed, missing and/or outstanding information. If an item is marked “completed” no further action is required.

**A. Forms to print out from this PDF and have mailed separately to the Board Office:**

- **Affidavit of Applicant (notarized – requires two notary stamps)** with recent photograph of applicant. **May be mailed by applicant**
- **Certification of Education** completed and mailed by your school not more than 13 weeks prior to graduation. **Must be mailed directly by your school**
- **Two Recommendation forms (total)** completed by two licensed physical therapists listed in your online application. New Graduates: your licensed PT Program Director, Professor, or Clinical Instructor may complete and submit form. **Must mailed by individual filling out the form**
- **Certification of Employment** Each employer going back 5 years must complete and submit form. **Must be mailed by employer**
- **Malpractice History** information for the 5-year period of active practice proceeding the application date. **May be mailed by applicant**

**B. Documents to be mailed directly to the Board Office:**

- **Official Transcript** with the degree granted and date degree was granted posted. **Must be sent directly from your school to the Board office via secure email or in a sealed envelope**
- **Verification of License** submitted to the Board Office from each state/country that you are or have been licensed

**C. Score Report (NPTE, ASI, PES)** Passing score must be transferred directly from FSBPT to the MN Board of PT

**D. Fingerprint-Based Criminal Background Check (CBC)**

- The Criminal Background Check Program will email you the fingerprinting and background check information and forms **after** you submit your online application and pay fees. A CBC is required for final licensure. NOTE: The CBC Program will contact you via the email address that you list on your initial online application.

**E. Miscellaneous Documentation (if applicable)**

- **If you answer YES to any of the practice questions**, please submit further legal/medical documentation. For legal documents: have the county or jurisdiction provide the MN Board with any legal documents (arrest records, court documents, dismissal of charges, etc.) related to the incident. Legal documents must be mailed to the Board

office by the jurisdiction. If the documentation cannot be mailed directly to us have the appropriate agency mail them directly to you and do not open the envelope. Please put the sealed envelope in a new envelope and mail to the Board office. If records are no longer available, have the jurisdiction send a letter indicating this.

- **Military Documents** – Copy of military discharge papers
- **Name Changes** - If you've had a name change, you will need to submit a legal document demonstrating your name change. You can submit an original certified copy or a notarized copy. The Board is unable to accept foreign marriage certificates that do not reflect your name change following marriage for purposes of changing your name on your license. [How to obtain a notarized copy of the document](#):

1. Make a photocopy of the document (certified marriage certificate, divorce or dissolution of marriage decree, court order, etc.)
2. Take the photocopy along with the original document to a Notary
3. The Notary will look at the original document and the photocopy
4. The Notary will sign/stamp/seal the photocopy and write a statement to the effect that they have viewed the original and this is an exact copy. Some Notaries will attach a paper (with a similar statement, signature/stamp/seal) to the copy

### **Board Meetings (application review dates and deadlines)**

It is your responsibility to make sure your file is complete and all requirements have been met. The Board will not review applicants with incomplete files. Applicants who answer "yes" to a question on their application or provide incomplete information are reviewed by the Licensure Committee at a PT Board meeting\*. Wall certificates and license cards will be issued after the Board meetings/review dates. \*On rare occasions a Board meeting date may be changed.

<b>Document Deadline</b>	<b>PT Board Meeting* or Review Date</b>
January 2, 2026	January 8, 2026
January 15, 2026	January 22, 2026
January 22, 2026	February 5, 2026*
February 12, 2026	February 19, 2026
February 26, 2026	March 5, 2026
March 12, 2026	March 19, 2026
March 26, 2026	April 2, 2026
April 9, 2026	April 16, 2026
April 23, 2026	April 30, 2026
April 24, 2026	May 6, 2026*
May 14, 2026	May 21, 2026
May 28, 2026	June 4, 2026
June 11, 2026	June 18, 2026
June 25, 2026	July 2, 2026
July 9, 2026	July 16, 2026
July 23, 2026	July 30, 2026
July 24, 2026	August 6, 2026*
August 13, 2026	August 20, 2026
August 27, 2026	September 3, 2026
September 10, 2026	September 17, 2026
September 24, 2026	October 1, 2026

October 8, 2026	October 15, 2026
October 22, 2026	October 29, 2026
October 23, 2026	November 4, 2026*
November 12, 2026	November 19, 2026
November 25, 2026	December 3, 2026
December 10, 2026	December 17, 2026

## Questions

If you have specific questions about the application process, please contact the Board at: 612.627.5406 (phone) or email the Board at: [physical.therapy@state.mn.us](mailto:physical.therapy@state.mn.us)

**Address all written correspondence to:**

MN Board of Physical Therapy  
335 Randolph Avenue, Suite 285  
St. Paul, MN 55102

**NOTE:**

- All Minnesota physical therapy (PT and PTA) licenses expire on December 31 of each year
- It is the applicant's responsibility to provide written notification to the Board within 30 days of an address change
- All physical therapist assistants practicing in Minnesota have a legal responsibility to comply with the Minnesota Physical Therapy Practice Act; view online at: <https://mn.gov/boards/physical-therapy/board-info/statutes-rules/practice-act/>
  - Minnesota Statutes 148.65-148.78
  - Minnesota Rules 5601.0100-5601.3200

**AFFIDAVIT OF APPLICANT:****PTA**

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 \_\_\_\_\_.

Signature of **Notary Public**

Notary Commission Expires: \_\_\_\_\_

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

The Board cannot accept photocopied or scanned images.

Affix **Notary Seal or Stamp**Signature of **Applicant**

0315

**Faxed or Emailed documents will not be accepted**

## PHYSICAL THERAPIST ASSISTANT CERTIFICATION OF EDUCATION

This form is for certification of Physical Therapist Assistant education for applicants applying for Minnesota licensure and must be completed and mailed by the University/College to the Minnesota Board of Physical Therapy. Any processing fees are applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to this Board.

**New Graduates:** The Program Director may mail this certification not more than 13 weeks prior to graduation. If the Program Director has any doubts about this applicant's graduation status then this form should not be completed or mailed prior to actual graduation.

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### THE SCHOOL COMPLETES THE FOLLOWING INFORMATION

It is hereby certified that: (Name of Applicant) \_\_\_\_\_

Matriculated in: (Name of School) \_\_\_\_\_

Accredited physical therapist assistant educational program located at: (Location of School) \_\_\_\_\_

This individual completed all didactic requirements and clinical internships successfully on: \_\_\_\_\_

**OR** \_\_\_\_\_

This individual was/will be granted a degree in physical therapist assistant on: \_\_\_\_\_

Select type of degree received / will receive: \_\_\_\_\_

Any disciplinary actions? Yes\* No \_\_\_\_\_

Any derogatory information on file? Yes\* No \_\_\_\_\_

**Program Director/Dean/Registrar**

Print Name: \_\_\_\_\_

School Seal\*\*

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\*Please attach letter of explanation.

Disciplinary action: formal action taken by the school/program, i.e., non-academic probation, dismissal, etc.

Derogatory information: behavior that may reveal a lack of professionalism as a potential threat to public safety.

\*\*If there is no school seal, attach letter of explanation on letterhead.

## PHYSICAL THERAPIST ASSISTANT RECOMMENDATION FORM

Two recommendation forms are required. Select two of the references (**physical therapists**) listed on your application to complete and submit this form.

**The individual providing this reference must mail this form via USPS directly to the Board at the above address.**

New Graduates: Physical therapy professors or clinical affiliation supervisors may be used.

**RECOMMENDATION FOR:** \_\_\_\_\_  
(*Applicant Name*)

1. How long have you known the applicant? \_\_\_\_\_

2. What has been the nature of your relationship with the applicant?  
\_\_\_\_\_

\_\_\_\_\_

3. How would you characterize the moral and professional conduct of the applicant?  
\_\_\_\_\_

\_\_\_\_\_

4. Would you recommend the applicant for approval for licensure as a physical therapist  
assistant? Yes No

5. Additional comments:  
\_\_\_\_\_

\_\_\_\_\_

### COMPLETED BY

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Professional Designation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Email address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PHYSICAL THERAPIST ASSISTANT RECOMMENDATION FORM

Two recommendation forms are required. Select two of the references (**physical therapists**) listed on your application to complete and submit this form.

**The individual providing this reference must mail this form via USPS directly to the Board at the above address.**

New Graduates: Physical therapy professors or clinical affiliation supervisors may be used.

**RECOMMENDATION FOR:**

*(Applicant Name)*

1. How long have you known the applicant?

2. What has been the nature of your relationship with the applicant?

3. How would you characterize the moral and professional conduct of the applicant?

4. Would you recommend the applicant for approval for licensure as a physical therapist assistant?  
Yes   No

5. Additional comments:

### COMPLETED BY

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Professional Designation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Email address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PHYSICAL THERAPIST ASSISTANT VERIFICATION OF LICENSURE

This form must be completed by the State Board in which you now hold, or have held a registration or license, and must be mailed by the state board directly to our office.

NOTE: Some states require a fee for this service, paid in advance. To expedite the process, you may wish to contact the state(s) prior to sending your request. Any processing fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to this Board.

Name: \_\_\_\_\_

SSN: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

.....  
THE STATE BOARD COMPLETES THE FOLLOWING INFORMATION:

<b>It is hereby certified that:</b> (Name of Applicant)		
<b>Date of birth:</b> (Month, Day, Year)		
<b>Was issued license/registration number:</b>		
<b>By:</b> (state)	<b>On:</b> (Month, Day, Year)	
<b>Expiration date is:</b> (Month, Day, Year)		
<b>Issued on the basis of:</b> (exam, reciprocity, endorsement)		
<b>Disciplinary action ever initiated, pending, or invoked*:</b>		
<b>Ever voluntarily relinquished license*:</b>		
	Print Name	
	Signature	
	Title	
	Date	

\*If yes, please attach letter of explanation

\*\*If there is no seal, attach letter of explanation on letterhead.

**FAXED DOCUMENTS WILL NOT BE ACCEPTED**

## PHYSICAL THERAPIST ASSISTANT CERTIFICATION OF EMPLOYMENT

**Applicant:** This form must be completed by your employer and mailed directly to our office by the employer. Any processing fees are the applicant's responsibility.

Name of Applicant: \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_

*This signature authorizes release of information, favorable or otherwise, directly to the Board.*

Date: \_\_\_\_\_  
.....

### THE EMPLOYER COMPLETES THE FOLLOWING INFORMATION

It is hereby certified that: (Name of Applicant) \_\_\_\_\_

Was/is employed by: (Name of Employer) \_\_\_\_\_

Address of Employer: \_\_\_\_\_

Phone Number of Employer: \_\_\_\_\_

Dates of Employment: From: \_\_\_\_\_ / To: \_\_\_\_\_ / (Month/Year)

### INDICATE BELOW FULL OR PART-TIME STATUS:

Full Time \_\_\_\_\_ Part time \_\_\_\_\_ Hours per week \_\_\_\_\_

Name of Administrator: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Subscribed and sworn to me this \_\_\_\_\_  
day of \_\_\_\_\_, \_\_\_\_\_  
Notary public \_\_\_\_\_  
My commission expires \_\_\_\_\_

Faxed or Emailed documents will not be accepted

## PHYSICAL THERAPIST ASSISTANT MALPRACTICE HISTORY FORM

1. Minnesota PTA License Application date: \_\_\_\_\_
2. Five-Year Period of Active Practice, preceding the application, starts on \_\_\_\_\_  
**(Use your graduation date if less than five years)** (month & year)
3. For this period please provide the following information:  
(a) Name and Address of Professional Liability insurer(s). Please attach additional pages if necessary

- (b) The number, date, and disposition of any malpractice settlement(s) or award(s). Please attach additional pages, if necessary. **If none, please write none.**

Print Full Name: \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

### Minnesota Statute 148.705 Malpractice history.

Subdivision 2 (b) A person who has previously practiced in another state shall submit the following additional information with the license application for the five-year period of active practice preceding the date of filing application in this state:

- (1) The name and address of the person's professional liability insurer in the other state.
- (2) The number, date, and disposition of any malpractice settlement or award made to the plaintiff relating to the quality of services provided.

Faxed or Emailed documents will not be accepted

## PHYSICAL THERAPIST ASSISTANT TEMPORARY PERMIT REQUEST FORM

This form and the \$25.00 fee are required to apply for a temporary permit.

I have read Minnesota Statutes 148.71 regarding the use of the temporary permit and hereby agree to abide by Minnesota Statutes and Rules governing physical therapist assistants.

---

**Applicant's Name (please print)**

---

**Signature of Applicant**

List name(s) of supervising physical therapist(s) and license number(s)

Professional address at which the temporary permit will be used  
(attach an additional sheet if more than one location)

Hospital/Clinic: \_\_\_\_\_

Department: \_\_\_\_\_

Address: \_\_\_\_\_

Professional telephone number(s): \_\_\_\_\_ (Include area code)

Anticipated date of commencing practice: \_\_\_\_\_

Address you wish to have the temporary permit mailed to:

---

**NOTE: It is your responsibility to immediately notify the Board if you wish to add or change the supervisor(s) and/or practice site(s) and receive Board approval prior to working under a new supervisor or at a new practice site.**