



STATE OF ALASKA
DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT
DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING
STATE PHYSICAL THERAPY AND OCCUPATIONAL THERAPY BOARD

P.O. BOX 110806
JUNEAU, ALASKA 99811-0806
TELEPHONE: (907) 465-2580
E-mail: license@alaska.gov
Website: <http://www.commerce.state.ak.us/occ/>

FOREIGN-TRAINED PHYSICAL THERAPIST OR PHYSICAL THERAPY ASSISTANT APPLICATION PACKET

A person may apply for licensure as a foreign-trained physical therapist or physical therapy assistant in the State of Alaska under the provisions of AS 08.84. Applicants may qualify for licensure by credentials (see Part I) or by examination (see Part III). Parts II and IV explain the qualifications for issuance of a temporary permit.

If you have questions concerning the licensing requirements described, please contact the licensing examiner for the State Physical Therapy and Occupational Therapy Board via email at: license@alaska.gov

IMMIGRATION

In accordance with AS 08.84.032(a)(4), the applicant must have met applicable requirements under the Federal Immigration and Nationality Act.

CREDENTIAL EVALUATION

If an applicant has not had his/her transcripts evaluated, the following credential evaluation company has been approved by the board for this service:

FOREIGN CREDENTIALING COMMISSION ON PHYSICAL THERAPY (FCCPT)
124 West Street South
Alexandria, VA 22314
(703) 684-8406
<http://www.fccpt.org>

If you use a company other than above, the board will review the evaluation on a case-by-case basis.

If an applicant cannot submit a transcript for evaluation as required, the board will, in its discretion, accept as evidence of education

- (1) verification from the licensing authority in another state that has evaluated the applicant's education; or
- (2) verification from an American educational institution or professional association that
 - (A) previously required documentary evidence of the applicant's education; or
 - (B) directly verified the applicant's education that has been evaluated.

TEST OF ENGLISH

A foreign-trained therapist must pass the Test of English as a Foreign Language (TOEFL); Test of Written English (TWE), and Test of Spoken English (TSE) OR the internet-based test (TOEFL-IBT) administered by the Educational Testing Services, P.O. Box 6151, Princeton, NJ 08541, Telephone (609) 771-7100. Refer to 12 AAC 54.040(j). **EVEN IF ENGLISH IS YOUR PRIMARY LANGUAGE OR YOUR ONLY LANGUAGE, YOU ARE REQUIRED BY LAW TO PASS THE ENGLISH EXAMINATIONS LISTED ABOVE.**

English language proficiency passing scores:

Test of English as a Foreign Language (TOEFL) 560 points written examination or 220 points computerized examination;
Test of Written English (TWE) – 4.50 points
Test of Spoken English (TSE) – 50 points

OR

Test of English as a Foreign Language Internet-Based Test (TOEFL – IBT)

Writing – 24 points
Speaking – 26 points
Reading Comprehension – 21 points
Listening Comprehension – 18 points

PART I – LICENSURE BY CREDENTIALS

The following documents must be in this office before the board will consider your application for licensure by credentials:

1. A completed notarized application and \$50.00 nonrefundable application fee. Make check or money order payable to the State of Alaska.
2. Initial licensure fee of \$230.00 for Physical Therapist or \$180.00 for Physical Therapy Assistant.
3. A Credentials Evaluation Report sent directly by the credentials evaluation service, or if you graduated from a School of Physical Therapy approved by the “Council on Medical Education and Hospitals of the American Medical Association,” or the “American Physical Therapy Association,” you only need to have your School of Physical Therapy submit certified transcripts (sent directly from school).
4. A report of your scores obtained in a national physical therapy examination. You must have received a passing score in accordance with regulation 12 AAC 54.080(a). Contact FSBPT at their website www.fsbpt.org to have your scores transferred electronically.
5. Verification of Licensure form completed by the state(s) where you hold or have ever held a license or permit to practice physical therapy, one of which shows that you have a current license in good standing (form 08-4091a).
6. Supervised Work Experience Verification form must be completed by a supervising physical therapist showing satisfactory evidence of a minimum of six months supervised work experience while licensed in another state, territory, or District of Columbia; or satisfactory completion of an internship program as described under Part IV of this application (form 08-4091c).
7. Professional Reference form (form 08-4091b) completed by the head of the physical therapy school, instructor, physician, or physical therapist other than the physical therapist preceptor described in 12 AAC 54.040(e)-(f).
8. Verification of successful passage of the English language proficiency examination sent directly from the Educational Testing Services (see page 1).

PART II – TEMPORARY PERMIT FOR FOREIGN-TRAINED CREDENTIAL APPLICANTS

The board will issue a temporary permit to practice physical therapy to an applicant who meets the criteria set out in AS 08.84.065. The temporary permit allows an applicant to practice while waiting to complete application for licensure by credentials. The following documents must be in this office before your application for a temporary permit will be considered:

All documents under Part I above plus the \$50.00 temporary permit fee.

PART III – LICENSURE BY EXAMINATION

Alaska offers the national physical therapy examination by computer through the Federation of State Boards of Physical Therapy. The board must approve your application to sit for the examination. The exam is offered in Alaska in one location, Anchorage. However, once approved by the board, you may sit for the examination at **any** Prometric Test Center in the United States.

A. Internship

Prior to making your request to take the National Physical Therapy Examination (NPTE), you must be accepted into a PT or PTA internship in accordance with 12 AAC 54.040. The 6 month internship must be approved by the board before you may begin it. The following items must be received by this office for the board's review:

1. A completed notarized application and \$50.00 nonrefundable application fee. (Make check or money order payable to the State of Alaska.)
2. Preceptor Statement for Internship of Foreign-Trained Physical Therapist (form 08-4091d).
3. A Credentials Evaluation Report sent directly by the credentials evaluation service, or if you graduated from a School of Physical Therapy approved by the "Council on Medical Education and Hospitals of the American Medical Association," or the "American Physical Therapy Association," you only need to have your School of Physical Therapy submit certified transcripts (sent directly from school).
4. A Professional Reference from the head of the physical therapy school, or an instructor, physician, supervising physical therapist or supervisor (form 08-4091b).

When your internship is completed, you must submit the following documents to the board:

1. Candidate Evaluation of Internship (form 08-4091f).
2. Preceptor Evaluation of Foreign-Trained Candidate (form 08-4091g).

It is recommended that you complete all English exams and the NPTE prior to the completion of your internship.

The board will review the evaluation forms and determine if the applicant has successfully completed the internship. If the board determines that the internship is complete and the applicant has not yet passed the NPTE examination, a temporary permit may be issued in accordance with Part IV.

B. Examination

When you are ready to take the examination, you must apply directly to the Federation of State Boards of Physical Therapy (FSBPT) at their website, www.fsbpt.org. Be sure to inform the board that you have registered to take the exam.

Programs under the jurisdiction of the Division of Occupational Licensing are administered in accordance with the Americans with Disabilities Act. If you require a special accommodation when taking the licensing examination, you must submit a completed "Application for Examination Accommodation for Candidates with Disabilities" form. This form is available on the division's website: www.dced.state.ak.us/occ/home.htm or contact the division to request the form.

C. Licensure

Before a license can be granted, the following items must be received:

1. Verification of completion of your internship. Candidate Evaluation of Internship (form 08-4091f) and Preceptor Evaluation of Foreign-Trained Candidate (form 08-4091g) must be completed and submitted.
2. Verification of passage of the English language proficiency examination (see page 1).
3. An initial license fee of \$230.00 for Physical Therapist or \$180.00 for Physical Therapy Assistant.

PART IV – TEMPORARY PERMIT FOR FOREIGN-TRAINED EXAM CANDIDATES

After an applicant has satisfactorily completed the required Alaska internship, the applicant can apply for a temporary permit only if the applicant has not taken the national physical therapy examination. The following documents must be in this office before a temporary permit will be issued:

1. Temporary permit fee of \$50.00 and license fee of \$180.00 for physical therapist or \$130.00 for physical therapy assistant.
2. All documents under “ A. Internship” requirement.
3. Verification of passage of the English language proficiency examinations (see page 1).
4. Temporary Permit Statement of Responsibility for Foreign-Trained Applicant (form 08-4091h).
5. Proof of the date you are scheduled to take the NPTE exam. (This can be obtained from the Prometric Computer Examination Center where you are scheduled.)

The temporary permit will expire on the date your NPTE Exam Scores are posted and your permanent license cannot be issued unless you have passed all English exams. It is, therefore, recommended that you complete all English exams and the NPTE prior to the completion of your internship.

GENERAL INFORMATION

Application processing is dependent upon how quickly the division receives all documents to complete a file. Once your application is complete, your application will be reviewed by the board either by “Mail Vote” or at a board meeting. The application process takes about four to six weeks, so please plan accordingly.

All licenses expire on June 30 of even-numbered years regardless of when issued, except licenses issued within 90 days of the expiration date will be issued to the next biennium. License fees are subject to change.

SOCIAL SECURITY NUMBERS – In accordance with AS 08.01.060(b), the department is not authorized to issue a license to an individual, unless the applicant’s social security number has been provided to the department. If you are a foreign citizen unable to obtain a United States Social Security Number, please contact the division for further instructions.

PAYMENT OF CHILD SUPPORT – Alaska Statute 25.27.244 requires the Division of Corporations, Business and Professional Licensing to deny issuance of the professional and occupational licenses of any person reported by the Alaska Child Support Enforcement Division (CSED) as not in substantial compliance with a child support order.

If the Alaska Child Support Enforcement Division has determined that you are in arrears on child support, or in the Alaska Commission on Post-Secondary Education has determined you are in loan default, you may be issued a nonrenewable temporary license valid for 150 days. Contact Child Support Enforcement at (907) 269-6657 if your last name begins with A through M; contact (907) 269-6845 if your last name begins with N through Z, or 1-800-478-3300.

PUBLIC INFORMATION – All information submitted with your application is considered public information, except information considered confidential by state or federal law. Information about current licensees, including mailing addresses, is available on the division’s website at www.commerce.state.ak.us/occ under “Professional License Search.”

PROFESSIONAL DATA

List the state(s) in which you hold or have ever held a license or temporary permit to practice physical therapy:

State: _____ License No. _____ Date Issued: _____ Expiration Date: _____
State: _____ License No. _____ Date Issued: _____ Expiration Date: _____
State: _____ License No. _____ Date Issued: _____ Expiration Date: _____
State: _____ License No. _____ Date Issued: _____ Expiration Date: _____
State: _____ License No. _____ Date Issued: _____ Expiration Date: _____

List any states in which you took a physical therapy examination:

a. State/Country: _____ Exam Date: _____ Passed: _____ Failed: _____
b. State/Country: _____ Exam Date: _____ Passed: _____ Failed: _____
c. State/Country: _____ Exam Date: _____ Passed: _____ Failed: _____

Expected Place of Employment in Alaska: _____

Mailing Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone: _____ Expected Beginning Date of Employment: _____

If applying for a Temporary Permit by examination, what is the name and Alaska license number of your supervising therapist?

Name: _____ License No. _____

Mailing Address: _____ State: _____ ZIP Code: _____

OCCUPATIONAL DATA

In chronological order, from most recent to most remote, list all relevant or related professional positions held. Provide names of employers, addresses, zip code, telephone numbers, positions held, duties, responsibilities, and name of direct supervisor(s):

1. Name of Employer: _____
Dates: From: _____ To: _____
Employer Address: _____
Employer Telephone No.: _____
Name of Supervisor: _____
Location of Practice if Different From Employer: _____
Position Held by Applicant: _____
Duties and Responsibilities: _____

2. Name of Employer: _____
Dates: From: _____ To: _____
Employer Address: _____
Employer Telephone No.: _____
Name of Supervisor: _____
Location of Practice if Different From Employer: _____
Position Held by Applicant: _____
Duties and Responsibilities: _____

3. Name of Employer: _____
Dates: From: _____ To: _____
Employer Address: _____
Employer Telephone No.: _____
Name of Supervisor: _____
Location of Practice if Different From Employer: _____
Position Held by Applicant: _____
Duties and Responsibilities: _____

4. Name of Employer: _____
Dates: From: _____ To: _____
Employer Address: _____
Employer Telephone No.: _____
Name of Supervisor: _____
Location of Practice if Different From Employer: _____
Position Held by Applicant: _____
Duties and Responsibilities: _____

(Attach other pages as necessary to complete this section.)

GENERAL INFORMATION - (If you answer "yes" to any question, please explain in full on a separate sheet and provide any applicable legal documentation.)

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Have you ever been disciplined by any state board or Physical Therapy Association concerning violation of the Physical Therapy Practice Act or unethical conduct? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been denied a license or had a license revoked, suspended, restricted, limited, or otherwise acted upon? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been denied the privilege of taking an examination before any state Physical Therapy Board?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever been convicted of any criminal offense(s) other than minor traffic violations (convictions include suspended imposition of sentences)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been convicted of a violation of any federal or state narcotic laws?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had any malpractice settlements or judgments paid in your behalf?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you now or have you been in the last five years treated for bipolar disorder, schizophrenia, paranoia, psychotic disorder, substance abuse, depression (except for situational or reactive depression) or any other mental or emotional illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you now or have you been in the last five years addicted to, or excessively used, or misused, alcohol, narcotics, barbiturates or habit-forming drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have a physical disability which could affect your ability to practice physical therapy?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Please be aware that all information provided with this application will be available to the public unless required to be kept confidential by state or federal law.

I hereby certify that the information in this application is true and correct to the best of my knowledge. I understand that any false information may result in failure to obtain licensure as a physical therapist, or physical therapy assistant in Alaska, or subsequent revocation of my license.



Signature of Applicant

NOTARY SEAL MUST OVERLIE PORTION OF PHOTOGRAPH.

SUBSCRIBED AND SWORN before me, a Notary Public, in and for the State of _____
 this _____ day of _____, 20____.

Notary Public

My Commission Expires: _____

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing
State Physical Therapy and Occupational Therapy Board
P.O. Box 110806
Juneau, Alaska 99811-0806
Telephone: (907) 465-2580
E-mail: license@alaska.gov

VERIFICATION OF LICENSURE

Applicant: Copy this form as needed. Some states require a fee for completion of license verification; you may wish to check with the state board prior to submitting this form to them for completion.

State Board:

I am applying for a license to practice **physical therapy** in the State of Alaska. The State Physical Therapy and Occupational Therapy Board requires that this form be completed by each jurisdiction in which I hold or have held licenses or permits. Please complete the form and return to:

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing
State Physical Therapy and Occupational Therapy Board
P.O. Box 110806
Juneau, Alaska 99811-0806

Signature: _____

Printed Name: _____

License No.: _____

Address: _____

The information below must be completed by the State Licensing Board; it **may not** be completed by the applicant.

State of _____

Name of Licensee _____

Graduate of _____

License No. _____ Type of License _____ Issued Effective _____

Permit No. _____ Issued Effective _____

By Reciprocity/Endorsement _____ By Examination _____

Date of Exam _____ Administered by _____

License or temporary permit is current _____ lapsed _____ Expiration Date _____

If the applicant's license or permit has lapsed or expired, please explain why (e.g., failure to pay licensing renewal fees, etc.)

Has the applicant's license or permit ever been suspended or revoked? _____ If so, for what reason?

Has the applicant been subject to any other disciplinary action(s) (e.g., letter of warning, stipulation)? Please describe.

Please provide any information you believe relevant to the applicant's qualifications and fitness to practice physical therapy:

General Comments: _____

[BOARD SEAL]

Signature

Printed Name

Title

State Board

Date

Please return completed form to:

Department of Commerce, Community
and Economic Development
Division of Corporations, Business
and Professional Licensing
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Juneau, AK 99811-0806

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Juneau, Alaska 99811-0806
Telephone: (907) 465-2580
E-mail: license@alaska.gov

PROFESSIONAL REFERENCE

Dear _____:

I am applying for a license to practice **physical therapy** in the State of Alaska. I am required to provide professional references to the State Physical Therapy and Occupational Therapy Board. Please complete information requested below and return the form directly to the Alaska Board. Thank you for your assistance.

Physical Therapists or Physical Therapy Assistants applying by examination must provide a professional reference from the head of the physical therapy school, or an instructor, physician, supervising physical therapist or supervisor.

Physical Therapists or Physical Therapy Assistants applying by credentials must provide a professional reference from the head of the physical therapy school from which the applicant graduated, or an instructor, physician, or physical therapist other than the physical therapist under which the applicant served an internship.

Signature: _____

Printed Name: _____

Address: _____

The information below **may not** be completed or returned by the applicant.

I certify that I was professionally associated with _____
(Name of Applicant)

from _____ to _____, and
month / year month / year

I recommend the applicant as being professionally capable, reliable, of good moral character and worthy of confidence.

STATEMENT OF DUTIES: _____

The State of Alaska believes a license to practice physical therapy carries important responsibilities. Please comment on the applicant's qualifications, ability, character, etc.:

Signature

Printed Name

Title

License No.
(if applicable)

Institution/Clinic Where Employed

Address

Business Phone Number

SUBSCRIBED AND SWORN before me, a Notary Public, in and for the State of _____
this _____ day of _____, 20_____.

NOTARY SEAL

Notary Public

My Commission Expires: _____

Please return completed form to:

Department of Commerce, Community,
and Economic Development
Division of Corporations, Business
and Professional Licensing
P.O. Box 110806
Juneau, AK 99811-0806

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Division of Corporations, Business and Professional Licensing
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Juneau, Alaska 99811-0806
Telephone: (907) 465-2580
E-mail: license@alaska.gov

SUPERVISED WORK EXPERIENCE VERIFICATION
(To be used only for licensure by credentials)

Dear Supervisor:

I am applying for a license to practice **physical therapy** as a foreign-trained therapist in the State of Alaska. I am required to provide evidence of supervised work to the State Physical Therapy and Occupational Therapy Board. Please provide the information requested below to the State of Alaska at the address shown below. Thank you for your assistance.

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing
State Physical Therapy and Occupational Therapy Board
P.O. Box 110806
Juneau, Alaska 99811-0806

Signature: _____

Printed Name: _____

Address: _____

The information below must be completed by your supervising physical therapist; it **may not** be completed or returned by the applicant.

Evidence of six (6) months supervised work experience (12 AAC 54.110(4))

I certify that I supervised _____
(Name of Applicant)

from _____ to _____, and

I recommend the applicant as being professionally capable, reliable, of good moral character and worthy of confidence.

STATEMENT OF DUTIES: _____

The State of Alaska believes a license to practice physical therapy carries important responsibilities. Please comment on the applicant's qualifications, ability, character, etc.:

Signature

Printed Name

Title

License No.
(if applicable)

Institution/Clinic Where Employed

Address

Business Phone Number

SUBSCRIBED AND SWORN before me, a Notary Public, in and for the State of _____
this _____ day of _____, 20_____.

NOTARY SEAL

Notary Public

My Commission Expires: _____

Please return completed form to:

Department of Commerce, Community,
and Economic Development
Division of Corporations, Business
and Professional Licensing
P.O. Box 110806
Juneau, AK 99811-0806

**PRECEPTORSHIP STATEMENT FOR INTERNSHIP
OF FOREIGN-TRAINED PHYSICAL THERAPIST**

This internship must be reviewed and approved by the board before the internship can take place. DO NOT BEGIN INTERNSHIP UNTIL APPROVED BY THE BOARD.

1. Name of Facility: _____
Type of Facility: _____

2. Mailing Address: _____
City: _____ State: _____ ZIP Code: _____
Telephone: _____

3. Date internship will start: _____ (**Note:** You must have board approval before internship can begin.)
Date facility would like board to review preceptor's report of performance: _____

4. Name of Supervisor: _____
Present Position: _____
Years Experience: _____

5. Professional staff in department and number of hours worked per week:
(Must have at least two full-time licensed physical therapists on staff)

6. Other staff in department:

7. Describe the facility case load by giving the approximate number of cases for the following categories:
(Preceptor is not expected to treat all types of patients.)

_____ A. Modalities	_____ C. Chronic – orthopedic – neurologic	_____ E. Sterile technique (wounds, burns, frostbite, etc.)
_____ B. Acute – orthopedic – neurologic	_____ D. Pediatric – orthopedic – neurologic	_____ F. Other (list) _____ _____

8. Describe the experience expected for the foreign-trained therapist (therapist is not expected necessarily to treat all types of patients, but must treat a variety of patients). Experience should be in any of the cases directed in #7 above.

9. Approximate number of patients seen per day or week for preceptor _____;
for department _____.
10. Provide brief descriptions of other programs, services, activities at facility (e.g., rounds, staffings, continuing education, etc.).

ACTIVITY

FREQUENCY

11. Possibilities for experience at other agencies/facilities: _____

12. Describe how direct on-site supervision by preceptor shall be provided:

I, the undersigned, agree to act as preceptor for _____, for a period of 6 to 12 months. At the end of a minimum of 6 months, I will provide a full report to the State Physical Therapy and Occupational Therapy Board describing performance during the internship. I understand the foreign-trained therapist applicant must be under my continuous, direct supervision for the length of the internship. I attest that I will be working full-time and I assume responsibility for the intern's experience and the safety and welfare of the patient.

Signature of Preceptor

Date

Please return completed form to:

Department of Commerce, Community,
and Economic Development
Division of Corporations, Business
and Professional Licensing
P.O. Box 110806
Juneau, AK 99811-0806

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State Physical Therapy and Occupational Therapy Board
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Telephone: (907) 465-2580
E-mail: license@alaska.gov

PRECEPTOR CREDENTIALS REVIEW
(For Federal Government Facilities: PHS and Military)

To be completed by the physical therapist employed by a federal facility, who wishes to serve as a preceptor of the internship required by AS 08.84.032(2), but who is not licensed in the State of Alaska.

1. Name of Preceptor: _____

2. Mailing Address: _____

City: _____ State: _____ ZIP Code: _____

3. Telephone: _____

4. Education:

Name of School	Location	Dates (From/To)	Degree or Number of Hours
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. Professional Experience (last five years):

Name and Address	Position	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. Have you ever taken a national examination for physical therapist? Yes No

Administered by: _____

Examination date: _____ Place administered: _____

7. Licensing Background – List all states in which you are licensed:

State	Date Issued	Status
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. GENERAL INFORMATION - (If you answer "yes" to any question, please explain in full on a separate sheet and provide any applicable legal documentation.)

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Have you ever been disciplined by any state board or Physical Therapy Association concerning violation of the Physical Therapy Practice Act or unethical conduct? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been denied a license or had a license revoked, suspended, restricted, limited, or otherwise acted upon? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been denied the privilege of taking an examination before any state Physical Therapy Board?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever been convicted of any criminal offense(s) other than minor traffic violations (convictions include suspended imposition of sentences)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been convicted of a violation of any federal or state narcotic laws?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had any malpractice settlements or judgments paid in your behalf?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you now or have you been in the last five years treated for bipolar disorder, schizophrenia, paranoia, psychotic disorder, substance abuse, depression (except for situational or reactive depression) or any other mental or emotional illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you now or have you been in the last five years addicted to, or excessively used, or misused, alcohol, narcotics, barbiturates or habit-forming drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have a physical disability which could affect your ability to practice physical therapy?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Please be aware that all information provided with this application will be available to the public, unless required to be kept confidential by state or federal law.

I hereby certify that the information in this application is true and correct to the best of my knowledge. I understand that any false information may result in failure to obtain approval as a preceptor.

Signature of Applicant

SUBSCRIBED AND SWORN before me, a Notary Public, in and for the State of _____
this _____ day of _____, 20_____.

NOTARY SEAL

Notary Public

My Commission Expires: _____

Please return completed form to:

Department of Commerce, Community,
and Economic Development
Division of Corporations, Business
and Professional Licensing
P.O. Box 110806
Juneau, AK 99811

CANDIDATE EVALUATION OF INTERNSHIP

Name of Candidate: _____

Name of Facility: _____

Date of Internship: _____

Describe quality and adequacy of the following items; please use back of sheet or second page for extra space.

1. Physical Setting (Facility)

a. Space/Layout: _____

b. Equipment: _____

c. Other: _____

2. Patient Exposure

a. Number of Patients: _____

b. Variety: _____

c. Scheduling: _____

3. Department of Administration

a. Level of Supervision: _____

b. Fairness of Supervision: _____

c. Adequacy of Staffing: _____

d. Staff Relationships: _____

e. Standards of Treatment: _____

COMMENTS

1. Was your role defined/understood at the beginning and throughout the internship? Was it appropriate?

2. What were the positive and negative aspects of this experience?

3. How would you improve the experience?

OTHER COMMENTS:

Signature: _____ Date: _____

PRECEPTOR EVALUATION OF FOREIGN-TRAINED CANDIDATE

Preceptorship For: P.T. _____
P.T.A. _____
Evaluation: Interim _____
Final _____

RATING	
1	= above average
2	= average
3	= below average
4	= unacceptable
N/A	= not applicable
N/E	= no experience

Name of Candidate: _____

Name of Preceptor: _____

Dates Inclusive: _____

Number of Hours Worked Per Week: _____

List duties performed by candidate during preceptorship:

List types of patients actually evaluated and treated by the candidate:

Experience with other department/agencies (describe in detail on separate sheet, if needed):

Using the Rating table above, rate and/or describe candidate's performance in following areas:

1. Quantity of work and effective use of time:
2. Quality of work:

_____ a. Modalities _____

_____ b. Acute — orthopedics _____
— neurologic _____

_____ c. Chronic — orthopedics _____
— neurologic _____

_____ d. Pediatric — orthopedics _____
— neurologic _____

_____ e. Sterile technique _____
_____ f. Other _____

3. Communication Skills:

_____ a. With patients and families (verbal and written) _____
_____ b. With staff _____
_____ c. Charting _____

4. Professionalism:

_____ a. Personal presentation _____
_____ b. Ability to work with staff, physicians, and other departments/agencies _____
_____ c. Judgement _____
_____ d. Ethics _____

5. Treatment Planning and Implementation:

_____ a. Scheduling _____
_____ b. Goal setting _____
_____ c. Implementation and discharge _____

6. English Proficiency: Is candidate's first language English? Yes No

_____ a. Verbal _____
_____ b. Written _____

COMMENTS:

Do you feel this candidate's work is adequate for independent practice? Yes No

If no, why? _____

Overall Rating: Excellent Good Fair Poor

Other Comments:

Signature of Candidate
(for interim evaluation only)

Signature of Preceptor

Date

Date

State of Alaska
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing
State Physical Therapy and Occupational Therapy Board
P.O. Box 110806
Juneau, Alaska 99811-0806
Telephone: (907) 465-2580
E-mail: license@alaska.gov

TEMPORARY PERMIT STATEMENT OF RESPONSIBILITY FOR FOREIGN-TRAINED EXAMINATION APPLICANT

This form must be submitted after a foreign-trained applicant has completed the six-month internship.

Date _____

To State Physical Therapy and Occupational Therapy Board:

I, _____, will assume the full responsibility of supervising
(Print Supervisor Name)

_____ in the practice of physical therapy.

Name of Facility Where Supervision will take place

located at _____

Mailing Address: _____

This supervision will be held in compliance with the statutes and regulations set forth by the State Physical Therapy and Occupational Therapy Board.

I understand that the applicant's temporary permit will expire when the results of the examination for which the applicant is scheduled are published. ("Published" means the date of notification of examination results from the Division of Corporations, Business and Professional Licensing to the applicant.) **If the applicant has not yet passed the required English exams at this point, they cannot obtain a permanent license.** I understand and agree that if the applicant fails to take the examination for which he/she is scheduled, the applicant's permit will lapse on the day of the scheduled examination and that he/she will not be eligible to continue practicing under the permit.

By my signature below, I certify that the above information is true and correct and that I will comply with the statutes and regulations set out by the Alaska Board of Physical Therapy and Occupational Therapy.

Signature of Supervisor

Alaska License Number: _____

SUBSCRIBED AND SWORN before me, a Notary Public, in and for the State of _____

this _____ day of _____, 20_____.

Notary Public

NOTARY SEAL

My Commission Expires: _____

Supervisor: Please return completed form to:

Department of Commerce, Community,
and Economic Development
Division of Corporations, Business
and Professional Licensing
P.O. Box 110806
Juneau, AK 99811-0806