



New York State Credentials Verification  
**REQUEST FOR ACADEMIC CREDENTIALS VERIFICATION**

**FOR APPLICANT TO COMPLETE AND SUBMIT TO FCCPT**

|                       |                  |                   |                     |
|-----------------------|------------------|-------------------|---------------------|
| <b>Name:</b>          |                  |                   |                     |
|                       | <b>Last Name</b> | <b>First Name</b> | <b>Middle Name</b>  |
| <b>Date of Birth:</b> | <b>Month:</b>    | <b>Day:</b>       | <b>Year:</b>        |
|                       |                  |                   | <b>File Number:</b> |

Name of School Attended: \_\_\_\_\_

Name of Recipient at School Attended: \_\_\_\_\_

Institution Address: \_\_\_\_\_  
Street City  
 \_\_\_\_\_  
State/Province Post/Zip Code Country

Applying to the New York State Education Department (NYSED) for licensure as a: \_\_\_\_\_  
Profession

The Foreign Credentialing Commission on Physical Therapy (FCCPT) has been authorized by the New York State Education Department to obtain and verify my academic records. Please COMPLETE THE ENCLOSED NEW YORK STATE ACADEMIC CREDENTIALS VERIFICATION FORM and release my official records (transcripts/marksheets/grade lists/etc.; detailed syllabus/detailed course content outlines; and certificate of clinical internship hours), for the period in which I completed education at your institution, to:

**Foreign Credentialing Commission on Physical Therapy**  
**124 West Street South, 3rd Floor**  
**Alexandria, Virginia 22314-2825**

Dates of Attendance: **From\*:** \_\_\_\_\_ **To\*:** \_\_\_\_\_  
\*If unsure of exact date, please enter attendance YEAR, at a minimum. (MM/DD/YYYY) (MM/DD/YYYY)

Name while attending this school: \_\_\_\_\_  
(if different from name above) Last First Middle

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
(Include Country and Area/City Code for Home and Work)

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

**I hereby authorize the release of my educational records to the Foreign Credentialing Commission on Physical Therapy (FCCPT).**

\_\_\_\_\_  
 Applicant Signature

\_\_\_\_\_  
 Date

**REGISTRAR: PLEASE COMPLETE THE ENCLOSED NEW YORK STATE ACADEMIC CREDENTIALS VERIFICATION AND INCLUDE WITH MY RECORDS.**