

FOR APPLICANT TO COMPLETE AND SUBMIT TO FCCPT

Name:							
Last Name			First Name			Middle Name	
Date of Birth:	Month:		Day:		Year:	File Number:	

Name/Title of Recipient: _____

Name of 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.