FCCPT
FOREIGN CREDENTIALING COMMISSION ON PHYSICAL THERAPY

Physical Therapist Credentials Evaluation

REQUEST FOR ACACEMIC CREDENTIALS VERIFICATION

SECTION ONE: FOR APPLICANT TO COMPLETE BEFORE SUBMITTING TO INSTITUTION			
Name:			
	Last Name	First Name	Middle Name

Date of Birth:	Month:		Day:		Year:		File Number:	

Institution/School Attended: ______________________________

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

Name while attending Institution: ______________________________
(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

SECTION TWO: FOR INSTITUTION TO COMPLETE BEFORE SUBMITTING TO FCCPT (CONTINUED ON PAGE 2)

Directions to Registrar: Please send this form along with the educational records (transcripts/marksheets/grade lists/etc.; detailed syllabus/detailed course content outlines; and certificate of clinical internship hours) of the applicant named above to:

FCCPT, 124 West Street South, 3rd Floor, Alexandria, VA 22314-2825

If there is no Registrar at the university or institution of higher learning, this form should be completed by the person charged with such duties. Should you have any questions please contact us at: ***Telephone, 703-684-8406; Fax, 703-684-8715; or E-mail, help@fccpt.org.***

Name of University/Institution: ______________________________

Name/Title of Official Completing this form: ______________________________

Institution Address: ______________________________
Street City

____
State/Province Post/Zip Code Country

Telephone: __________________ Fax: __________________ Email: __________________

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Physical Therapist Credentials Evaluation

REQUEST FOR ACACEMIC CREDENTIALS VERIFICATION

SECTION TWO: FOR INSTITUTION TO COMPLETE BEFORE SUBMITTING TO FCCPT (CONTINUED FROM PAGE 1)

Applicant's Name: ______________________________
(as a student)

Name of Degree/Diploma Awarded: ______________________________

Credential(s) Required for Program Admission: ______________________________

Dates of Attendance: From: ____________ *(MM/DD/YYYY)* To: ____________ *(MM/DD/YYYY)*

Graduation Date: ____________ *(MM/DD/YYYY)*

Check this box if applicant did not graduate from this institution: ☐

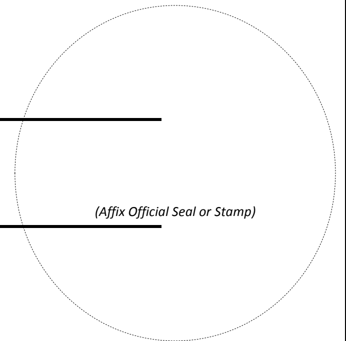
Length of Program: ____________
(number of years)

Signature and Seal are required for completion of this form

I hereby attest that my responses are complete and accurate to the best of my knowledge. In witness whereof, I hereby set my hand and seal of this institution this ___________ day of ______________________, 20_________.

Registrar's Name, or other Official: ______________________________
(Please Print)

Registrar's /Official's Signature: ______________________________



Please include ALL educational records belonging to the applicant named on this form. Records may include Transcripts, Transcript of Hours, Marksheets*, and/or Grade Lists; Detailed Syllabus or Detailed Course Outlines; and Certificate of Clinical Internship Hours.

***_Note:_ Marksheets must come with corresponding Transcript of Hours in order to be accepted for evaluation purposes.**