

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

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

Applicant's Cell Phone: \_\_\_\_\_  
(Include Country and Area/City Code)

Applicant's 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 [help@fccpt.org](mailto: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: \_\_\_\_\_ Email: \_\_\_\_\_

**CONTINUED ON PAGE 2**

**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: \_\_\_\_\_ To: \_\_\_\_\_  
*(MM/DD/YYYY)* *(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)*

Language of Instruction: \_\_\_\_\_ Language of Textbooks: \_\_\_\_\_

If applicant cannot be cleared for graduation at this time, please indicate the reason, e.g. all requirements for the certificate, diploma or degree have not been met and/or the individual has outstanding financial obligations to the institution.

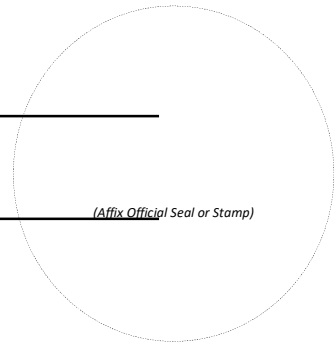
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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: \_\_\_\_\_ *(Affix Official Seal or Stamp)*



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

**\*Note: Marksheetworks must come with corresponding Transcript of Hours in order to be accepted for evaluation purposes.**