

FOR OFFICIAL USE ONLY

PTA Exam Application

Name: _____ <input type="checkbox"/> End: _____ <input type="checkbox"/> Ex: _____ <input type="checkbox"/> Rev by End: _____ <input type="checkbox"/> Exost: _____ _____ Board Approved by: _____ _____ _____	Examination Date: _____ / _____ / _____ ID Number: _____ / _____ / _____ Exam Form Number: _____ / _____ / _____ SCORES: Scaled: _____ / _____ / _____ Raw: _____ / _____ / _____ NC Passing: Scaled: _____ / _____ / _____ Raw: _____ / _____ / _____	Date Received: ____/____/____ Fee: _____ Dep#: _____ _____ License No: _____ _____ Issued Date: _____ _____ Granted By: <input type="checkbox"/> End: _____ <input type="checkbox"/> Ex: _____ <input type="checkbox"/> Rev by End: _____ <input type="checkbox"/> Exost: _____
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North Carolina Board of Physical Therapy Examiners Application for Physical Therapist Assistant Licensure

Name: Mr. Ms. Mrs. Dr. / <u>First Name:</u> _____					<u>Middle Name:</u> _____					<u>Last Name:</u> _____					<u>Maiden Name:</u> _____				
Present Address: _____																			
Until (_____)																			
City: _____					State: _____					Zip code: _____									
<input type="checkbox"/> Telephone Area Code: (_____)					Social Security No. _____					Birth Place: _____					Birth Date: _____				
Email Address: _____																			

I. PRINT your name exactly as you want it to appear on your certificate of licensure.

Professional Education

II. List physical therapist assistant program conferring degree or certificate.

SCHOOL AND LOCATION	DATES ATTENDED	DEGREE OR CERTIFICATE
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Professional Licensure

III. List ALL states in which you have ever been licensed regardless of status of license at this time.

STATE	License #	DATE OF ORIGINAL LICENSE	METHOD OF LICENSE (EXAM, ENDORSEMENT, etc.)	IS LICENSE CURRENT
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1. _____
2. _____
3. _____

(list additional licenses on a separate sheet and attach)

Professional Employment

IV. When and where do you anticipate employment in North Carolina?

a. DATE	PLACE	SUPERVISOR
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b. If employed as a contract therapist, list name and address of employer.

c. Starting with PRESENT position list your professional employment.

DATES	NAME AND ADDRESS OF INSTITUTION	SUPERVISOR
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1. _____
2. _____

(list other places of employment on a separate sheet and attach)

OVER

- V. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:
- | | YES | NO |
|--|-------|-------|
| 1. Have you ever used a name other than the one on the front of the form?
If yes, give name(s) _____ | _____ | _____ |
| 2. Have you ever taken the physical therapist assistant licensing examination? | _____ | _____ |
| 3. Have you ever been denied the privilege of taking a physical therapist assistant licensing examination?
If yes, give state(s): _____ | _____ | _____ |

IF YOU ANSWER YES TO ANY OF THE FOLLOWING QUESTIONS, GIVE DETAILS ON A SEPARATE SHEET AND ATTACH.

- | | | |
|--|-------|-------|
| 4. Has disciplinary action ever been taken or is pending against you by a PT Licensing board? | _____ | _____ |
| 5. Have you ever used drugs or alcohol to the extent it adversely affects professional competence? | _____ | _____ |
| 6. Have you ever been convicted for violating any narcotic or controlled substance law? (Do not include convictions that have been expunged.) | _____ | _____ |
| 7. Have you ever been convicted of a felony or other public offence involving moral turpitude? (Do not include convictions that have been expunged.) | _____ | _____ |
| 8. Have you ever been found to have committed an act or acts of malpractice, gross negligence or incompetence in the practice of physical therapy? | _____ | _____ |
| 9. Have you ever had an adjudication of insanity or incompetence? | _____ | _____ |

VI. FEES: **Certified check or money order** payable to: NC Board of Physical Therapy Examiners must accompany application. Personal or business checks will be returned.
Application fee is **NOT** refundable

- Check One:
- | | |
|---|----------|
| <input type="checkbox"/> Applying for licensure by endorsement | \$150.00 |
| <input type="checkbox"/> Applying for licensure by examination in another state | \$150.00 |
| <input type="checkbox"/> Applying for licensure by examination in North Carolina:
(examination cost \$485.00 to be paid directly to FSBPT) | \$150.00 |

Exam Candidates: List preferred examination date: _____

If you have a disability and need an accommodation at the exam, check here _____ . You will receive a Request for Accommodation Form which must be submitted at least 90 days before the examination.

VII. AFFIDAVIT

By signing the application I, _____, do hereby state that I am the person referred to in this application for a license to practice as a physical therapist in North Carolina and to the best of my knowledge and belief the statements in my application are true in every respect. The attached photograph is a true likeness of me. I authorize former employers, schools, references, testing services and other licensing boards to give any job related, personal or licensing information they may have regarding me. I hereby release them from all liability for issuing such information.



Sign in the presence of a Notary Public

Sworn to me before this _____ day of _____, 20____

Signature of Notary Public (affix seal): _____

My commission expires: _____

SEND FORM AND CERTIFIED CHECK OR MONEY ORDER TO:

N.C. Board of Physical Therapy Examiners
8300 Health Park Suite 233
Raleigh, NC 27615



NORTH CAROLINA BOARD OF PHYSICAL THERAPY EXAMINERS

Employee Misclassification

Public Notice Statement

Required by N.C. Gen. Stat. § 143-764(a)(5), effective December 31, 2017

Any worker who is defined as an employee by N.C. Gen. Stat §§ 95-25.2(4)(NC Department of Labor), 143-762(a)(3)(Employee Fair Classification Act), 96-1(b)(10)(Employment Security Act, 97-2(2)(Workers' Compensation Act), or 105-163.1(4)(Withholding; Estimated Income Tax for Individuals) shall be treated as an employee unless the individual is an independent contractor. Any employee who believes that the employee has been misclassified as an independent contractor by the employee's employer may report the suspected misclassification to the Employee Classification Section within the North Carolina Industrial Commission.

Employee Classification Section
North Carolina Industrial Commission
1233 Mail Service Center
Raleigh, NC 27699-1233
Telephone: (919) 807-2582
Fax: (919) 715-0282
Email: emp.classification@ic.nc.gov

Employee misclassification is **defined** as avoiding tax liabilities and other obligations imposed by Chapter 95, 96, 97, 105, or 143 of the North Carolina General Statutes by misclassifying an employee as an independent contractor. (N.C. Gen. Stat. § 143-762(5))

Please read the public notice statement above and then check the box below to certify that you have read it. (failure to answer this question will result in a denial of (licensure/renewal) per N.C. Gen. Stat. 143-765(b)).

I have read and understand the public notice statement above.

In the past five (5) years have you been investigated for employee misclassification as defined in the public notice statement above? If yes, please list the result of each occurrence (if additional space is required, please attach separate pages to this document).

Yes

No

List Each Occurrence:

Signature/Date: _____



NORTH CAROLINA BOARD OF PHYSICAL THERAPY EXAMINERS

CERTIFICATION OF PHYSICAL THERAPIST ASSISTANT EDUCATION

To be completed by applicant

Name: Mr. Ms. Mrs. Dr. _____ Maiden Name: _____
 Address: _____
 City: _____ State: _____ Zip code: _____ Class of: _____

(APPLICANT MUST NOT COMPLETE ANY OF THE SECTIONS BELOW)

To be completed by the school:

If the didactic and clinical work has been completed and the degree is assured, but will not be conferred until a later date, the applicant will be considered to have been graduated.

Complete the section that pertains to the applicant as of this date.

A. GRADUATE:
 I hereby certify that: _____
 (name of applicant)
 successfully completed the didactic and clinical education requirements of the physical therapist assistant program at _____ (name of school)
 on: _____ The date of the: _____ is _____
 (month) (day) (year) (type of degree, certificate) (month) (day) (year)

OR

B. Assured Graduation (see Definition attached)
(When the program is completed, the Director will be verify the applicant's graduation.)
 I hereby certify that: _____
 (name of applicant)
 is **assured** of completing the didactic and clinical education requirements of the physical therapist assistant program at _____
 (name of school)
 by: _____, and a _____ will be granted on _____

(impress Seal of institution over signature)

SEAL

Signature of authorized representative of school

School address

Type name and title

City

State

zip code

Date:

If school does not have a seal, form must be notarized.

I, _____ do hereby state that this institution does not have an official seal and that the statements on this form are true in every respect. Signed: _____ Sworn to before me this _____ day of _____, 20____. Signature of Notary Public (affix seal): _____ my commission expires: _____

**Do not give this form back to applicant. Form must be returned directly by the school to: N.C. Board of Physical Therapy Examiners
8300 Health Park Suite 233 Raleigh, NC 27615**

Attn PT and PTA Program Directors:
In response to 21 NCAC 48A.0105 DEFINITIONS:

21 NCAC 48A .0105 DEFINITIONS

The following definitions and the definitions in G.S. 90-270.24 will apply throughout Chapter 48:

- (4) "Graduated" or "graduation" means the completion of all requirements, including clinical experience, from an accredited program for physical therapists or physical therapist assistants. If an educational program certifies that the degree is assured and will be conferred at a later date, an applicant will be considered to have been graduated.

Board is requesting that you complete section "B, **Assured Graduation**", of the Education Form to assure completion of the didactic and clinical education requirements, which is needed in order to allow the students to take the examination prior to final graduation and to minimize the delay that could occur between the completion of all requirements for graduation and graduation prior to a scheduled examination date.

Final Step: For Final Graduation, you can provide one list of graduates. The list can be Faxed: 919-490-5106 or Emailed: angela.licensing@ncptboard.org . We will need this final list for issuing score information.

If you have any questions about this process, please contact the Board office at 919-490-6393 or email angela.licensing@ncptboard.org



North Carolina Board of
Physical Therapy Examiners

Character Reference

Check One

Applying for Licensure
PT____ or PTA____
____ by Endorsement
____ by Exam in _____

To be completed by applicant

Name: Mr. Ms. Mrs. Dr. _____ Maiden Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

To be completed by a person who has known the applicant for at least one year and is not a relative:

This certifies that I have been acquainted with _____
(name of applicant)

from _____ (month / year) to _____ (month / year)

in the following capacity: _____

I can attest to the good moral character of

(name of applicant)

Good moral character means a “personal history of honesty, fairness, and respect for the rights of others and the laws of the state and nation.” If there is any additional information concerning the good moral character or technical fitness of the applicant that you feel the Board should know, please attach a written explanation.

Do not give this reference to the applicant.

Reference must be returned directly by person writing it to:

**NC Board of PT Examiners
8300 Health Park, Suite 233
Raleigh, NC 27615**

(Signature)

(Print or type name and title)

(Address)

City, State, and Zip Code

Date



North Carolina Board of
Physical Therapy Examiners

Character Reference

Check One

Applying for Licensure
PT____ or PTA____
____ by Endorsement
____ by Exam in _____

To be completed by applicant

Name: Mr. Ms. Mrs. Dr. _____ Maiden Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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8300 Health Park Suite 233
Raleigh, NC 27615**

(Signature)

(Print or type name and title)

(Address)

City, State, and Zip Code

Date

Federation of State Boards of Physical Therapy (FSBPT)

FSBPT COMPUTERIZED TESTING PAYMENT - Payment will need to be made directly to the FSBPT for the examination cost.

For Complete Instructions:

Log onto the FSBPT web site, <https://www.fsbpt.org>