

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Health Professional Licensing Administration
for the D.C. Board of Physical Therapy



* **INDIVIDUAL** *

APPLICATION FOR CONTINUING EDUCATION COURSE APPROVAL

1. _____
Name of Sponsoring Organization

2. _____
Street Address

3. _____
City State Zip Code Area Code and Telephone #

4. Person Responsible _____
Title _____

5. Program Title _____

6. Number of clock hours requested (minimum of 50 minutes = 1 clock hour; no fractions allowed)

7.	<u>Course Site</u> (City, State)	<u>Course Date</u>
-	-----	-----
-	-----	-----

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health**

Health Professional Licensing Administration
for the D.C. Board of Physical Therapy



8. How does this course relate to the practice of physical therapy?

9. Attach: (a) a description of the course objectives;
(b) an outline of the course content;
(c) a description of the teaching methods to be employed and
(d) a description of any instructional media to be utilized.

10. Enclose a copy of promotional material, if available.

Printed Name of the Person Submitting this Application

Date

License Number

Mailing Address: _____

*** Only the following types of physical therapy continuing education programs are exempt from prior review and approval by this administration: All continuing education programs provided directly by the American Physical Therapy Association (APTA) or the Federation of State Boards of Physical Therapy (FSBPT), relevant undergraduate or graduate courses given at an accredited college or university, and hospital in-service trainings.**