

APPLICATION FOR APPROVAL OF CONTINUING PHYSICAL THERAPY EDUCATION FOR COURSE PROVIDERS

Florida Physical Therapy Association Continuing Education Department

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FPTA Accreditation Number:

Notice of Decision by FPTA:

Approved Denied

Date: _____ FPTA Staff: _____

CE Broker Course Tracking # 20- _____

Application is for Calendar Year 20_____

PLEASE TYPE INFORMATION OR PRINT LEGIBLY

NOTE: Applications submitted by course providers must be received **30 days prior to course dates.**

1. Name of Course Provider:

2. Provider's Contact Person:
E-mail:

3. Phone (Area Code)
FAX (Area Code)

4. Provider's Mailing Address:

5. Please list Dates and Locations in Florida:

6. Type of Sponsor/Provider:

- District of FPTA ()
- Nursing Home
- Professional CE Provider
- Educational Institution (Non Approved)

- Health Care Licensee
Type: _____
- Hospital
- Other _____

7. Fee: Fee must be received with application in the form of a credit card (MC, VISA or American Express), check, or money order made payable to Florida Physical Therapy Association.

Course Provider: *

- \$80.00 (1-3 contact hrs.)
- \$150.00 (4-7 contact hrs.)
- \$225.00 (8 contact hrs. or greater)

*If course is not approved, the fee less \$50.00 is refundable. (If all information is not provided, there may be additional fees.)

Type of Card: ___Mastercard ___VISA ___American Express

Credit Card Number _____ Exp Date _____

8. Program or Course Name:

9. Nature of Program:

- Live Presentation /Class/Lecture
- Homestudy/Audio/Video/Internet
- Teleconference/Satellite-Live/Real Time
- Conference
- Other - Please describe

10. Please attach program outline that fully describes course and time devoted to each topic, including program objectives. .

One CEH = 50 minutes

.5 CEH = 25 minutes

(Does not include breaks or scheduled meal times.)

PLEASE ESTIMATE YOUR CONTINUING EDUCATION CONTACT HOURS (CEHs) REQUESTED.

11. Please attach curriculum vitae/bio for each speaker; include professional licenses and numbers, academic degrees, educational institutions attended and credentials to teach course, relevant clinical experience or experience relevant to teaching course material. (A summary of this information, i.e., course brochure, is acceptable.)

12. Describe relevance of program content to the profession or practice of Physical Therapy. Attach separate sheets as necessary.

13. Is there any pending litigation or complaint filed against your license and/or expertise? (Course Providers Only)

Yes No

If, yes, please explain:

NOTE: Course attendance (scan sheets) is due upon completion of course not to exceed 90 days. Scan sheets are to be mailed to:
Department of Health Assurance
Division of Medical Quality
CE Tracking Unit, BIN C01
4052 Bald Cypress Way
Tallahassee, FL 32399-3251

The information provided in this application is true and complete to my knowledge.

Name of Person Submitting Application: _____

Signature of Applicant: _____

Date: _____

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Indicate total CEHs in the following areas of certification:

_____ Professional ethics	_____ Clinical education	_____ Clinical practice
_____ Clinical research	_____ Clinical management	_____ Clinical science
_____ Basic sciences	_____ Risk management	_____ HIV/AIDS
_____ Florida law relating to physical therapy	_____ Medical errors	

_____ TOTAL CONTINUING EDUCATION CONTACT HOURS