

INDIVIDUAL

APPLICATION FOR APPROVAL OF CONTINUING EDUCATION

Florida Physical Therapy Association
Continuing Education Department
2104 Delta Way, Suite 7, Tallahassee, FL 32303
850/513-0083 • FAX 850/224-5281
Email: con.ed@fpta.org • www.fpta.org

FOR OFFICE USE ONLY	
20____	
FPTA Accreditation Number: _____	
Course Name: _____	
Notice of Decision by FPTA:	
<input type="checkbox"/> Approved	<input type="checkbox"/> Denied
Date: _____	FPTA Staff: _____
CE Broker Published Tracking # 10- _____	
Date _____	

PLEASE TYPE INFORMATION OR PRINT LEGIBLY

NOTE: Applications submitted by individual licensees for attendance at a non pre-approved program must be received prior to course dates or within sixty (60) days after the expiration of the same licensure period in which the course was completed. **Course providers may not use this application.**

1. Name, Address & Phone Number of Individual Applicant::

2. Name of Course Provider:
Email:

3. Course Providers:
Phone (Area Code)
FAX (Area Code)

4 Course Provider's Mailing Address:

5. Please list Date & Location of the course

6. 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.
Individual Licensee seeking Individual Approval:
 \$20.00 (Submitted prior to course dates or within sixty (60) days after attendance at the program.) (non-refundable)
 \$100.00* (Submitted later than sixty (60) days after attendance at the program.)
 Exempt as FPTA program / APTA Component Program / Accredited PT/PTA program.
*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 _____

7. Program or Course Name:

8. Nature of Program:
 Live Presentation/Class/Lecture
 Homestudy/Audio/Video/Internet
 Teleconference/Satellite-Live/Real Time
 Conference
 Other - Please describe _____

9. Please attach program outline that fully describes course and time devoted to each topic, including program objectives. Please estimate your **CONTINUING EDUCATION CONTACT HOURS (CEHs) REQUESTED.**

One CEH = 50 minutes

.5 CEH = 25 minutes

(Do not include breaks or scheduled meal times.)

Indicate total estimated 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 REQUESTED

10. 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.)

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

12. Please include a copy of the certificate of completion for the course you are applying for approval. CE hours will not be submitted to CEBroker without the certificate of completion.

The information provided in this application is true and complete to my knowledge. (Please Print)

Name of Person Submitting Application: _____

Signature of Applicant: _____

Date: _____

License Number of Person seeking approval: _____
(must be included for application approval)