

Nevada Physical Therapy Board



3291 North Buffalo Drive, Suite 100 · Las Vegas, NV 89129
Phone (702) 876-5535 · Facsimile (702) 876-2097

MAIL IN LICENSE RENEWAL APPLICATION

Please check applicable box

Physical Therapy - \$150.00 Physical Therapist Assistant - \$100.00

Make all payments payable to: Nevada Physical Therapy Board

To renew your license and receive your current license (aka renewal certificate), you must submit this completed form and pay the required fee.

Be certain to **answer all questions on the form** including the Continuing competency requirement section. This education must be obtained between the current license period start date and the date of this renewal. Fraudulently representing, or failure to obtain continuing competency as represented on this renewal/continuing competency form could result in disciplinary action.

Please **list the primary professional address and personal information** below. Primary professional address means the physical address where a licensee practices physical therapy or carries out any other activities relating to physical therapy for the majority of his working hours within a consecutive 30-day period.

Pursuant to NAC 640.055, if a licensee changes name after the license is issued, licensee must submit, within 30 days after the change, proof satisfactory to the Board that the name was legally changed. If the change of name resulted from marriage or a court decree, a copy of the marriage certificate or court decree must be submitted to the Board. By default, the names are disabled and cannot be changed.

CLICK HERE IF YOU DO NOT INTEND TO RENEW YOUR LICENSE License # _____

PERSONAL INFORMATION

Legal Name:

First Name: Middle Name:
Last Name: Date of Birth:

Mailing Address:

Military Address: (Click here if this is a military address)
Street:
City: State: Zip:

Email Address:

Home Phone:

Effective Date of Address Change:

Cell Phone:

PRIMARY EMPLOYER INFORMATION (list the employer name and primary professional address)

Not Employed

Start Date:

Employer Name:

Employer Address:

Work Phone:

Work Fax:

NEVADA BUSINESS LICENSE INFORMATION

I DO NOT have a Nevada Business license number.

I HAVE APPLIED for a Nevada Business License with the Nevada Secretary of State in Compliance with provisions of NRS Chapter 76 and my application is pending.

I have a Nevada Business License number assigned by the Secretary of State in compliance with the provisions of NRS Chapter 76.

Name on business license:

Business License #:

The State of Nevada Physical Therapy Examiners' Board is not the arbiter of determining whether the applicant needs a business license. Information about the Nevada business license can be found on the Secretary of State's website at: <https://www.nvsos.gov/sos>.

CHILD SUPPORT INFORMATION – An Answer is Mandatory– Check ONE Appropriate Answer

Mark the appropriate response (failure to mark one of the three will result in denial of your application):

I am **NOT SUBJECT** to a court order for the support of a child.

I am **SUBJECT** to a court order for the support of one or more children and am in compliance with the order, or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

I am **SUBJECT** to a court order for the support of one or more children and am NOT in compliance with the order or am NOT in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

MILITARY SERVICE INFORMATION – As required by Executive Order 2014-20

Are you an active member of the Armed Forces? Yes No

Are you a member's spouse, veteran or veteran's surviving spouse? Yes No

Branch(es) of Services: (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Army/Army Reserve | <input type="checkbox"/> Marine Corps/Marine Corps Reserve |
| <input type="checkbox"/> Navy/Navy Reserve | <input type="checkbox"/> Air Force/Air Force Reserve |
| <input type="checkbox"/> Coast Guard/Coast Guard Reserve | <input type="checkbox"/> National Guard |

Military Occupation Speciality/Specialities:

Date(s) of Service: From: To:

Attached a copy of your military discharge record or military identification.

LEGAL INFORMATION

1. Since the date of your last application or renewal, has your license, registration or certification in any state ever been denied, revoked, suspended, reprimanded, fined, surrendered, restricted, limited or placed on probation?
 Yes No
2. Are there any action pending against your license in any state?
 Yes No
3. Since the date of your last application or renewal, have you had a problem related to the habitual use of alcohol or drugs, or been diagnosed and/or treated for addiction?
 Yes No
4. Since the date of your last application or renewal, have you been arrested, charged or convicted of a violation of Federal Law, State Law or Municipal Ordinance other than a traffic violation?
 Yes No
5. Since the date of your last application or renewal, have you been diagnosed, treated or hospitalized for a psychiatric or mental health condition that will result in your not being able to practice the essential job function of a licensed physical therapist/physical therapist's assistant?
 Yes No
6. Since the date of your last application or renewal, have you been diagnosed as having a physical or medical condition which will result in your not being able to practice the essential job functions of a licensed physical therapist/physical therapist's assistant?
 Yes No

CONTINUING COMPETENCE INFORMATION

List date of completion; course(S), and CE Hours awarded for continuing competence credit that was completed in the **previous 12 months**.

Course Sponsor	Course Title	Course Start Date	Course End Date	CE Hours

The Nevada Physical Therapy Board (“Board”) requires all licensees to report compliance with continuing competence requirements pursuant to NRS 650.150.

I am recording completed courses and activities, and have uploaded certificates of completion documentation.

ACKNOWLEDGEMENT

I hereby certify to the State Board of Physical Therapy Examiners that I have obtained the required continuing education during the licensure period that is currently active, through and including this date, as provided in NAC 640.510(1); and NAC 640.400, and declare, under penalty of perjury, all the information supplied herein is to the best of my knowledge true, accurate and complete and I have not withheld, misrepresented, or falsely stated any information relevant to my training or experience or my fitness to practice physical therapy.

Signature:

Date of Application:

Note: Licensees shall retain a certificate of completion awarded for completing a course of study or training for continuing education for four (4) years after completion of the course of training. A copy of the certificate must be submitted to the Board upon request to verify completion of the course of study or training. Failure to provide the requested certificate(s) may subject the licensee to disciplinary action. Any false, incorrect or misleading statements(s) on this form may subject the licensee to disciplinary action.

FOR OFFICIAL USE ONLY:

Date Received: Signature: