

LOUISIANA PHYSICAL THERAPY BOARD
Telephone (337) 262-1043 Fax (337) 262-1054

PHYSICAL THERAPY EXAMINATION APPLICANTS COMPLETE THIS SECTION.

SUPERVISORY REQUEST

_____ will be under my direct supervision while he/she is
Name of Applicant
practicing physical therapy at _____
Worksite Name, Address, and Telephone Number of Facility
Beginning _____
Date of Employment

I understand that the applicant MAY NOT begin work until the applicant is interviewed by a Board representative and a Provisional License is issued.

How many licensed physical therapists work in your department? _____
Are you currently supervising any other support personnel? Yes No
If yes, how many, excluding this applicant? _____
_____ Year graduated from Physical Therapy School

FACILITY WORK TYPE

- | | | |
|------------------------------------|--|--|
| <input type="radio"/> Hospital | <input type="radio"/> Private Practice | <input type="radio"/> Physicians Office |
| <input type="radio"/> Rehab Center | <input type="radio"/> Extended Care Fac. | <input type="radio"/> Home Health Agency |
| <input type="radio"/> School Sys. | <input type="radio"/> Academic Environment | <input type="radio"/> Outpatient Clinic |

It is my understanding that this is required by the Louisiana Physical Therapy Practice Act Revised Statutes 37:2410.A.(5).

I accept the responsibility for the physical therapy clinical supervision of the provisional license holder. During the assigned supervision period, I understand that I must:

- 1. Maintain my license in good standing with the Board
- 2. Supervise not more than one provisional licensee,
- 3. Be readily available at all times to provide advice to the provisional licensee and to the patient during the Physical Therapy treatment given by the provisional licensee,
- 4. Assign to the provisional licensee only such Physical Therapy measures, treatments, procedures, and functions that I have documented that the provisional licensee is capable of performing safely and effectively.
- 5. Perform periodic review of the status of every patient administered to the by the provisional licensee and make modifications and adjustments in the patients' treatment plans as necessary.

If for any reason, I am unable to fulfill the above requirements, or if I discontinue supervision of the provisional licensee, I will notify the Board immediately.

I have read and understand the above requirements. Should I fail to properly fulfill my obligations as outline, I understand that my license shall be subject to sanctions by the Board.

This signed form does not constitute permission for the provisional license holder to begin practice in the listed facility under the named supervisor until such time as the Board has approved the supervisor and facility and the provisional license holder has in his possession on a provisional license with the appropriate and current information.

By clicking on the check box to the left, PT swears or affirms that all information presented here is true and correct to the best of my knowledge and belief.

_____	_____	_____	_____
Name	Signature	License	Date
(Last, First, Middle Initial)	(Only if submitting via Fax or Mail)	Number	