

ORTHOPEDIC PHYSICAL THERAPY CLINICAL RESIDENCY PROGRAM APPLICATION

(Please print legibly)

Resident Applicant Profile

Name _____ Date _____

Home Address _____ City _____

State _____ Zip _____ Phone Number _____ FAX Number _____

Home Email Address _____

Work Address _____ City _____

State _____ Zip _____ Phone Number _____ FAX Number _____

Home Email Address _____

APTA membership number _____

Emergency Contact _____ Emergency Phone Number _____

Professional License Detail

State:	License Type:	License No.	Issue Date:	Expiration Date:
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Board Certification Detail

Issuing Board	Certification Credential	Certificate No.	Issue Date	Expiration Date

Please list the issuing organization and expiration date of your current CPR certification _____

Employment Status

Date of Hire	Employment Description <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Pool or PRN
Current Job Title	

Do you require any special accommodations to ensure a satisfactory learning experience? yes no If yes, please detail.

Checklist: Please ensure that each of the following items accompany your application. The application will not be processed until all of these documents are submitted.

- ✓ Copy of professional practice license(s) with expiration date
- ✓ Two letters of endorsement (both letters should be from a licensed health care provider with at least one from a person who was your supervisor). Recommendations from physical therapists will be most strongly considered. These letters of endorsement may be submitted separate for this application but sent to the same address as below.
- ✓ Current curriculum vitae or professional resume
- ✓ CPR certification card with expiration date

It is the applicant's responsibility to submit four complete copies of the entire application and its supporting documentation.

Upon completion, this application should be sent to Ed Mulligan at the UT Southwestern Department of Physical Therapy; 5323 Harry Hines Blvd; Dallas TX 75390-8876

Signatures:

Applicant _____

Date _____

ATTESTATION QUESTIONS

Please answer the following questions "Yes" or "No". **If your answer to any of the questions is "Yes", please provide complete details on a separate sheet.**

QUESTION	Yes	No
1. Has your license to practice medicine in any jurisdiction ever been denied, limited, suspended, revoked, not renewed, or subject to probationary conditions, or have you been fined or received a letter of reprimand - or is such action pending?		
2. Has your Drug Enforcement Administration (DEA) certification or an applicable narcotic certification ever been restricted, limited, suspended, revoked, not renewed, or subject to probationary conditions, or have you been fined or received a letter of reprimand, or are such actions pending with respect to your DEA certification? If applicable		
3. Have your hospital privileges at or with a healthcare organization (e.g. medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payor, medical society, professional association, medical school facility position or other health delivery entity or system) ever been denied, restricted, limited, suspended, revoked, not renewed; have disciplinary proceedings ever been instituted against you; or are any of these actions now pending? If applicable		
4. Have you ever surrendered clinical privileges, terminated contractual participation or employment, or resigned from any medical/healthcare organization (e.g. medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payor, medical society, professional association, medical school facility position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or in return for such an investigation not being conducted, or is any such action pending?		
5. Has your participation in Medicare, Medicaid, or other government program ever been denied, limited, suspended, revoked, not renewed, or subject to probationary conditions; or, to the best of your knowledge, have you ever been under investigation by a regulatory agency?		
6. Have you ever been convicted of a felony or do you have any felony or misdemeanor charges pending other than traffic offenses; or history of crimes against children?		
7. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization even been revoked, denied, limited, or not renewed, or is any such action pending?		
8. Have you ever been denied certification/recertification, or has your eligibility status changed with respect to certification/recertification by a specialty or governing board?		
HEALTH STATUS		
9. Are you unable to perform all of the professional services for which you have been licensed with or without reasonable accommodation, according to all accepted standards of professional performance and without posing a direct threat to the safety of patients?		
10. Do you now have, or have you had, a chemical dependency or any mental health problem(s) or are you currently receiving professional care for substance abuse or any similar treatment?		
11. Are you currently taking any medications that may affect either your clinical judgment or motor skills?		
12. Are you using drugs illegally?		

Practitioners Signature: _____ Date: _____

(STAMPED SIGNATURE IS NOT ACCEPTED)

Printed Name: _____