

CONTINUING EDUCATION UNITS

Name: _____ License No.: _____

Address: _____

City: _____ State: _____ Zip: _____

PROGRAM INFORMATION

Program Title: _____

Program Location: _____

Date(s) of Instruction: _____

Program Objectives: _____

Program Content: _____

Program Instructor or Speaker: _____

Program Sponsor: _____

Sponsor Address: _____

Sponsor City: _____ Sponsor State: _____ Sponsor Zip: _____

Total Continuing Education Units: _____ **Total Contact Hours:** _____

(One unit equals 10 contact hours.)

Attach course brochure, certificate of completion and other additional material showing a detailed schedule of course and specific objectives.

Mail to:
Arkansas State Board of Physical Therapy
9 Shackleford Plaza, Suite 3
Little Rock, AR 72211

***NOTE: This form must accompany each course submitted for credit.
Duplicates of the form for additional courses are permissible.***