

ARKANSAS STATE BOARD OF PHYSICAL THERAPY

Application for Continuing Education Units

Sponsor Information

Sponsored by: _____

Address: _____

Phone: () _____ Fax: () _____ E-Mail: _____

Co-Sponsor: _____

Address: _____

Phone: () _____ Fax: () _____ E-Mail: _____

Signature of person(s) authorized to sign course completion certificates: _____

Printed name of person(s) authorized to sign course completion certificates: _____

Program Information

Program Title: _____

Program Location: _____

Program Date(s): _____

Program Objectives: _____

Program Content: _____

Total Contact Hours (excluding breaks)

Attach course brochure or 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

BOARD USE ONLY

Course approved by: _____ # of hours _____

Date: _____