

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

**PHYSICAL THERAPIST ASSISTANT EXAMINATION APPLICANTS COMPLETE THIS SECTION.**

**VERIFICATION OF SUPERVISION**

\_\_\_\_\_ will be under my direct supervision while he/she is

NAME OF APPLICANT

practicing physical therapist assisting 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 (Check one)**

\_\_\_\_\_ Hospital

\_\_\_\_\_ Private Practice

\_\_\_\_\_ Physicians Office

\_\_\_\_\_ Rehab Center

\_\_\_\_\_ Extended Care Fac.

\_\_\_\_\_ HomeHealthAgency

\_\_\_\_\_ School Sys.

\_\_\_\_\_ Academic Environment

\_\_\_\_\_ Outpatient Clinic

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

I accept the responsibility for 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 two provisional licensees,
3. Be readily available at all times to provide advice to the provisional licensee and to the patient during 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 by the provisional licensee and make modifications and adjustments in the patient's 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.

If have read and understand the above requirements. Should I fail to properly fulfill my obligations as outlined, 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 a provisional license with the appropriate and current information.**

\_\_\_\_\_  
PT signature, License Number, and Date