Louisiana Physical Therapy Board
104 Fairlane Drive | Lafayette, Louisiana 70507
Phone 337-262-1043 | Fax 337-262-1054
www.laptboard.org | info@laptboard.org

PHYSICAL THERAPY EXAMINATION APPLICANTS COMPLETE THIS SECTION
SUPERVISORY REQUEST FORM

_____ 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? (Circle One) Yes No If yes, how many, excluding this applicant? _____

Year graduated from Physical Therapy School _____

FACILITY WORK TYPE

_____ Academic/Higher Education	_____ Occupational Environ (Industrial, Wkplace)	_____ Research Center
_____ Acute Care	_____ Outpatient (Hospital-Based)	_____ Retired
_____ Extended Care/Nursing Hm/Skilled Nursing	_____ Outpatient (Other Owner)	_____ School/Preschool
_____ Government (Local, State, or Federal)	_____ Outpatient (Physician-Owned)	_____ Sub-Acute Rehabilitation
_____ Home Health	_____ Outpatient (PT/PTA-Owned)	_____ Unemployed
_____ Hospice	_____ Rehabilitation Hospital	_____ Wellness/Prevention/Sports/Fitness

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 signing below, I agree that all information presented in this documentation form is true and correct to the best of my knowledge and belief.

_____	_____	_____	_____
Print Name *(Last, First, Middle Initial)*	Signature	License Number	Date