

**APPLICATION FOR APPROVAL OF CONTINUING EDUCATION COURSE**  
**Individual Provider**

Continued competency means a planned learning experience relating to the scope of physical therapy practice as defined by KRS 327.010(1) if the subject is intervention, examination, research, documentation, education or management of health care delivery systems.

Sponsor Name: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Program Title:**

<b>Program Format:</b>	<input type="checkbox"/> Lecture/Lab	<input type="checkbox"/> Video	<input type="checkbox"/> Correspondence	<input type="checkbox"/> Online	<input type="checkbox"/> Other				
<b>Key Word/Category:</b>	<input type="checkbox"/> Cardiopulmonary	<input type="checkbox"/> Neuromuscular	<input type="checkbox"/> Musculoskeletal	<input type="checkbox"/> Integumentary	<input type="checkbox"/> Pediatric	<input type="checkbox"/> Women's Health	<input type="checkbox"/> Management	<input type="checkbox"/> Professional Issues	<input type="checkbox"/> Other

Date(s): \_\_\_\_\_ Location(s): \_\_\_\_\_

Intended Audience:  PT  PTA  Students  Other (specify) \_\_\_\_\_

Has this program been approved for Continuing Education by another agency or association?

No  Yes (if yes please specify)

Date Approved \_\_\_\_\_ Agency \_\_\_\_\_

Contact Hours: (excluding meals and breaks) \_\_\_\_\_

The following information must accompany this application: (attach course brochure if inclusive of information listed below). Failure to include requested documentation may result in application being delayed or rejected.

1. Timed Outline or Agenda
2. Course Description
3. Course Objectives
4. Program Evaluation
5. Copy of Certificate of Completion
6. Home-study or online courses must submit a copy of the post-test and the minimum passing score and/or a certificate of completion
7. Biographical data for each speaker to include pertinent educational and clinical experience
8. Application fee of \$100 (no fee for corporate sponsors)
9. Include a self addressed, stamped envelope for reply
10. For guidelines on continued competency see APTA's Policy on Professional Development, Lifelong Learning and Continuing Competence at [http://www.apta.org/uploadedFiles/APTAorg/About\\_Us/Policies/HOD/Professional\\_Development/ProfessionalDev.pdf](http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/HOD/Professional_Development/ProfessionalDev.pdf)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Return to: **KPTA, 15847 Teal Road, Verona, KY, 41092, (859) 485-2812, FAX (859) 485-2813**

**Do not write below this line:**

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*For Office Use Only:*

\_\_\_\_\_ Denied Reason \_\_\_\_\_

\_\_\_\_\_ Approved KPTA Approval # \_\_\_\_\_ Approval Expiration Date \_\_\_\_\_

*KPTA approval # and expiration date must be included on the course completion certificate*

Approval Committee Signature: \_\_\_\_\_ Date: \_\_\_\_\_