STATE OF CONNECTICUT

Department of Public Health

PHYSICAL THERAPIST ASSISTANT
TEMPORARY PERMIT

INSTRUCTIONS TO THE APPLICANT:

1. Have the supervising physical therapist complete Part II of this form.
2. Return the form to the Physical Therapist Assistant Licensure, 410 Capitol Ave., MS# 12 APP, P.O. Box 340308, Hartford, CT 06134.
3. Upon receipt of this form by the Department, the applicant will be mailed an official temporary permit.
4. If you should change employers, a new permit will be required.

PART 1: TO BE COMPLETED BY THE APPLCIANT

Name: _____

Address: _____

Social Security Number: _____/_____/_____ Date of Birth: _____/_____/_____

_____ _____
Signature of Applicant Date

PART II: TO BE COMPLETED BY THE SUPERVISING PHYSICAL THERAPIST

Name: _____

Office Address: _____

Telephone No. _____ License No. _____

I certify that I am employed in the facility where the temporary permittee will be employed. I understand that direct supervision requires my immediate physical presence at all times that the temporary permittee engages in physical therapy services.

_____ _____
Signature of Supervising Physical Therapist Date