VERIFICATION OF LICENSE - PHYSICAL THERAPY

Access this form via website at: **hawaii.gov/dcca/pvl**

State of Hawaii
Board of Physical Therapy
P.O. Box 3469
Honolulu, HI 96801

To be completed by applicant:

APPLICANT

Name (First, Middle)	(LAST)	
Address (Include Apt. No., City, State and Zip Code)	Social Security No.	License No. PT -
	Date of Birth	Date Issued

I hereby authorize the licensing agency of the state of _____ to furnish the information below to the State of Hawaii Board of Physical Therapy.

SIGN HERE: _____ Date: _____

To be completed by licensing agency:

LICENSING AGENCY

This is to certify that the above-named individual was issued license number _____ to practice physical therapy.

Date issued: _____

Date license expires: _____

License status: ☐ current

☐ lapsed since: _____

☐ inactive since: _____

Has this license ever been encumbered in any way (revoked, suspended, surrendered, limited, placed on probation, currently pending disciplinary action, being investigated)? ..... ☐ NO

☐ YES (Please explain a "Yes" response and attach copy of Boards order and related information.)

Signature: _____

Print Name: _____

Title: _____

State Licensing Board: _____

Address: _____

_____

_____

Date: _____

BOARD SEAL
(If none, state "none")

*TO THE BOARD: Return this form **directly** to the Hawaii Board of Physical Therapy.*

Print Form

(This form may be duplicated)