



# Volunteer Application

*Directions:* Please limit your application to the space provided on this form. Print or type in the space provided. To be considered, e-mail, fax or mail this form *with a copy of your résumé or curriculum vitae* to:

FSBPT Volunteer Application  
Federation of State Boards of Physical Therapy  
124 West Street South, 3<sup>rd</sup> Floor  
Alexandria, Virginia 22314  
Fax: 703.299.3110  
ATTN: Assessment Department  
E-mail: volunteer@fsbpt.org

**Date:** \_\_\_\_\_

## Contact Information

Name	
Street Address 1	
Street Address 2	
City, ST ZIP Code	
Home Phone	
Work Phone	
Fax	
E-Mail Address	

## Interests

Tell us in which areas you are interested in volunteering

- NPTE - PT
- NPTE - PTA
- Practice Review Tool

## State Licensure

Please list the states where you currently hold an active license.

	PT	PTA
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

Date of Initial Licensure: Month: \_\_\_\_\_ Year: \_\_\_\_\_

## Other Information

In order to develop a group of volunteers that is representative of the physical therapy profession; please provide the following information:

Gender:  Male  Female  
 Professional Level:  PT  PTA

Race/Ethnicity:  African American  
 American Indian/Native American  
 Asian American/Pacific Islander  
 Hispanic American  
 White  
 Other

Are you an APTA member?  Yes  No  
 Do you own or have access to a computer with a connection to the internet?  Yes  No  
 Have you ever **applied** to be an FSBPT volunteer before?  Yes  No

If Yes, in what year did you apply? \_\_\_\_\_

Have you ever **served** on an FSBPT committee before?  Yes  No

If yes, on what committee and in what year did you serve?  
 \_\_\_\_\_ Committee(s) \_\_\_\_\_ Year

## Physical Therapy: Practice Setting

Please indicate your primary practice setting with a "1". Indicate second and third practice settings with "2" and "3" if needed. Please list no more than 3 practice settings.

<input type="checkbox"/> Academic Institution	<input type="checkbox"/> Inpatient Rehab
<input type="checkbox"/> Extended Care of Skilled Nursing Facility	<input type="checkbox"/> Outpatient Facility
<input type="checkbox"/> Home Health	<input type="checkbox"/> Private Practice
<input type="checkbox"/> Hospital	<input type="checkbox"/> School Setting
<input type="checkbox"/> Other	

If Other Please Explain:

How many years have you been in your current practice setting?  Under 5 years  
 5 to 10 Years  
 10 to 15 years  
 15 to 25 years  
 25 or more years

## Physical Therapy: Areas of Expertise

Please rank order your primary area of expertise using a "1". Please list secondary and tertiary expertise areas with "2" or "3" if they apply. Next, indicate what % of your time you spend in each area.

Topic	Rank	% of Time Spent
Acute Care		
Administration		
Amputee		
Cardiopulmonary		
Clinical Education		
Geriatrics		
Industrial Rehab		
Spine/Mobilization		
Orthopedics		
Other		
Neuromuscular: Spinal Cord Injury		
Neuromuscular: Head Injury		
Neuromuscular: Other		
Obstetrics/Gynecology		
Pediatrics		
Research		
Wound Care		
Sports PT		

If Other Please Explain:

What percentage of time do you spend on direct patient care? \_\_\_\_\_

**PTs Only:**

What percentage of time do you currently work with PTAs? \_\_\_\_\_