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STATE OF DELAWARE

EXAMINING BOARD OF PHYSICAL THERAPISTS AND ATHLETIC TRAINERS

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VERIFICATION OF SUPERVISION COMPLETION FOR PHYSICAL THERAPIST, PHYSICAL THERAPIST ASSISTANT OR ATHLETIC TRAINER

INSTRUCTIONS

For Reactivation/Reinstatement of a License

UPLOAD THIS DOCUMENT FROM THE SUBMIT ADDITIONAL DOCUMENTATION OPTION IN DELPROS.

This form must be submitted to the Delaware Examining Board of Physical Therapists and Athletic Trainers ***after*** the completion of the required 6-months of supervised practice in a clinical setting. The Board office cannot reactivate or reinstate the license until it receives this verification of supervision completion form. The requirements for reactivation or reinstatement of a license are set forth in Section 11.0 of the Board's rules and regulations.

Section I – To be completed by the licensee.

The supervisor **must** complete Section II on the form and return the signed document to you to upload with your service request or reinstatement application in DELPROS. If you had more than one supervising Physical Therapist (PT) or Athletic Trainer (AT), ***each*** supervisor must submit a completed form.

LICENSEE INFORMATION FOR REACTIVATION OR REINSTATEMENT REQUEST

2. Licensee Name: _____ _____ _____
   Last First Middle

3. Delaware License Number: **J** ___ - _____

Section II – To be completed by the supervising PT/AT.

The supervising PT or AT completes, signs and returns the form to the licensee for submission with the licensee's service request or reinstatement application. The supervisor is responsible for the actions of the licensee under the supervisor's ***direct*** supervision. The supervisor must be on the premises at all times that the licensee is working. If the licensee had more than one supervising PT or AT, ***each*** supervisor must submit a completed form.

SUPERVISOR INFORMATION – To be completed by the supervising PT or AT.

4. Supervisor's Name on License: _____ _____ _____
   Last First Middle
5. Delaware License Number: J___ - _____
6. Address Where Supervision Occurred: _____
   Practice Name
   _____ _____ **DE** _____
   Street City State Zip

SUPERVISION CERTIFICATION

☐ I certify that _____ has successfully completed the required 6-month supervised practice under my direct supervision and has demonstrated clinical competence.

Supervisor Signature: _____ Date:_____