GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH
HEALTH PROFESSIONAL LICENSING ADMINISTRATION

SUPPLEMENTAL INFORMATION FORM

(PLEASE PRINT IN INK OR TYPE)

NAME: _____ **DATE:** _____
Last, First, MI

ADDRESS: _____
Number and Street, City, State, Zip Code

TYPE OF LICENSE

____ PHYSICAL THERAPIST ____ PHYSICAL THERAPIST ASSISTANT

1. Are you addicted to drugs, chronic or persistent inebriety, afflicted with contagious disease or physical or mental disability? ____ Yes ____ No If *"Yes,"* attach explanation.

2. Have you ever taken the National Physical Therapy Examination (NPTE)? ____Yes ____No

   If *"Yes,"* what state? _____

   Examination Date_____ Were your scores accepted as passing by that state? ____Yes ____No

3. Character Reference List. List the names and addresses of three responsible persons (other than relatives, instructors or employers) who have known you for at least one year and can attest to your character.

	Name	**Address (including Zip Code)**	**Title & Position**
1.			
2.			
3.			

EXPERIENCE

Name of Employer	**Address (city/state)**	**Position**	**From – To (mm/yy)**
1.			
2.			
3.			

If your practice has been limited to a specialty, state which one: _____

From:_____ To: _____