DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

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MURIEL BOWSER, MAYOR

DEPARTMENT OF HEALTH PROFESSIONAL LICENSIG 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,"* attached explanation.

2. 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: _____