

A.R.S. §32-2001, Definitions

13. "Practice of physical therapy" means:

(a) Examining, evaluating and testing persons who have mechanical, physiological and developmental impairments, functional limitations and disabilities or other health and movement related conditions in order to determine a diagnosis, a prognosis and a plan of therapeutic intervention and to assess the ongoing effects of intervention.

(b) Alleviating impairments and functional limitations by managing, designing, implementing and modifying therapeutic interventions including:

(i) Therapeutic exercise.

(ii) Functional training in self-care and in home, community or work reintegration.

(iii) Manual therapy techniques.

(iv) Therapeutic massage.

(v) Assistive and adaptive orthotic, prosthetic, protective and supportive devices and equipment.

(vi) Pulmonary hygiene.

(vii) Debridement and wound care.

(viii) Physical agents or modalities.

(ix) Mechanical and electrotherapeutic modalities.

(x) Patient related instruction.

(c) Reducing the risk of injury, impairments, functional limitations and disability by means that include promoting and maintaining a person's fitness, health and quality of life.

(d) Engaging in administration, consultation, education, and research.



ARIZONA STATE BOARD OF PHYSICAL THERAPY
1740 West Adams Street Suite 2450 • Phoenix, Arizona 85007
Telephone (602)274-0236 • web: ptboard.az.gov

REINSTATEMENT OF AN ADMINISTRATIVELY SUSPENDED LICENSE AND LICENSE RENEWAL

AFFIRMATION OF EMPLOYMENT STATUS

FOR PERSONS WHO **HAVE** PRACTICED WITH AN ADMINISTRATIVELY SUSPENDED LICENSE

NAME: _____ DATE: _____

License / Certificate Number: _____

I have reviewed the statutory definition of “practice of physical therapy” at A.R.S §32-2001(13). I affirm that I have continued to practice as a physical therapist or physical therapist assistant since my license/certificate was administratively suspended on September 1, 2020.

The following must be completed. If you require more space, attach a separate sheet that includes all the information requested below.

Name of facility, clinic, etc	Address / City / State / Zip	Phone w/Area Code	Dates of Employment AFTER Expiration Date of License/Certificate

I am aware that until my license/certificate has been reinstated and renewed I may not legally practice as a physical therapist or physical therapist in Arizona.

I am aware that practicing as a physical therapist or physical therapist assistant with an administratively suspended license is in violation of A.R.S. §32-2048 and may be grounds for disciplinary action pursuant to A.R.S. §32-2044. The Board has the investigative authority to validate your employment status.

Signed: _____ Date: _____



If you prefer to consult with legal counsel prior to signing this affirmation, or to write your own affirmation, please be aware that you may not practice until your reinstatement and renewal application is complete (including an affirmation of employment status), your fees have been paid and your reinstatement has been processed.

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REINSTATEMENT OF AN ADMINISTRATIVELY SUSPENDED LICENSE AND LICENSE RENEWAL

AFFIRMATION OF EMPLOYMENT STATUS

FOR PERSONS WHO **HAVE NOT** PRACTICED WITH AN ADMINISTRATIVELY SUSPENDED LICENSE

NAME: _____ DATE: _____

License / Certificate Number: _____

Section 1: Check all that apply:

- I affirm that currently I am not practicing in the State of Arizona
- I affirm that currently I am not residing in the State of Arizona

Section 2:

- I have reviewed the statutory definition of “practice of physical therapy” at A.R.S.§32-2001(13). I affirm that I am employed in Arizona but have not practiced as a physical therapist or Physical therapist assistant since my license was administratively suspended on September 1, 2020.

Name of place of employment: _____

Address: _____
Street City State Zip Code

Telephone #: () _____

I am aware that until my license/certificate has been reinstated and renewed I may not legally practice as a physical therapist or physical therapist in Arizona.

I am aware that practicing as a physical therapist or physical therapist assistant with an administratively suspended license is in violation of A.R.S. §32-2048 and may be grounds for disciplinary action pursuant to A.R.S. §32-2044. The Board has the investigative authority to validate your employment status.

Signed: _____ **Date:** _____

If you prefer to consult with legal counsel prior to signing this affirmation, or to write your own affirmation, please be aware that you may not practice until your reinstatement and renewal application is complete (including an affirmation of employment status), your fees have been paid and your reinstatement has been processed.

For Staff Use Only

In Compliance Out of Compliance

**Arizona State Board of Physical Therapy
Continuing Competence Audit Reporting Form
Compliance Period: _____**

PT/PTA Name: _____ **License/Cert #** _____ **Date** _____

To qualify as a Category A activity a course must be approved for contact hours by a PT, medical or health care 1) accredited program, 2) state or national association or component of the association or 3) national specialty society. Regardless of the sponsoring organization, approval by a Category A organization will qualify a course as Category A, whether the course is taught in a classroom, on the internet or through home study. Category A activities include continuing education coursework, coursework towards granting or renewal of PT clinical specialty certification, coursework in a PT clinical residency program and coursework in post-graduate PT education from an accredited college or university, including transitional DPT programs. In addition, courses approved through the Federation of State Boards of Physical Therapy ProCert process are considered Category A.

CATEGORY A MIN 10 hrs PT, 6 hrs PTA					FOR AUDITOR USE ONLY		
Title of course, seminar, etc.	Date(s) of course	Contact Hours	CEUs Approved By (Category A organization)	Documents Attached	Hours approved	Hours not approved	Reason for disapproval
(Pg 2 on Reverse side of this page) TOTALS							

MAKE SURE YOUR DOCUMENTATION INCLUDES DATE, PLACE, COURSE TITLE, COURSE SPONSOR, SCHEDULE, PRESENTER, NUMBER OF CONTACT HOURS RECEIVED FOR THE ACTIVITY AND PROOF OF COMPLETION.

PT/PTA Name: _____

License/Cert # _____

Date _____

CATEGORY B	Description of category activities below.				FOR AUDITOR USE ONLY		
Title of course, seminar, etc.	Date(s)	Contact Hours	CEUs Approved By	Documents Attached	Hours approved	Hours not approved	Reason for disapproval
B1 Study Group—MAX 5 hrs PT, 2 hrs PTA	Structured meeting for study of clinical PT topic dealing with current research, clinical skills, procedures or treatment related to practice of PT. Minimum of 3 participants; each 2 hours participation=1 contact hour.						
B2 Self-Instruction—MAX 5 hrs PT, 2 hrs PTA	Structured course of study relating to one clinical physical therapy topic dealing with current research, clinical skills, procedures, or treatment related to practice of PT. 60 minutes of self-instruction=1 contact hour.						
B3 In-Service—MAX 5 hrs PT, 2 hrs PTA	Attendance at a presentation pertaining to current research, clinical skills, procedures or treatment related to practice of PT OR relating to patient welfare of safety, including CPR certification. 60 minutes of inservice=1 contact hour.						
TOTALS							

MAKE SURE YOUR DOCUMENTATION INCLUDES DATE, PLACE, COURSE TITLE, COURSE SPONSOR, SCHEDULE, PRESENTER, NUMBER OF CONTACT HOURS RECEIVED FOR THE ACTIVITY AND PROOF OF COMPLETION.

PT/ PTA Name: _____

License/Cert # _____

Date _____

CATEGORY C	Description of category activities below.				FOR AUDITOR USE ONLY		
Title of course, seminar, etc.	Date(s)	Contact Hours	CEUs Approved By	Documents Attached	Hours approved	Hours not approved	Reason for disapproval
C1 Practice Management—MAX 5 hr PT 2 hr PTA	Coursework concerning physical therapy administration, professional responsibility, ethics, or legal requirements applicable to PT practice settings. Must receive 'pass' in pass/fail or minimum grade of 'C' if graded. 60 minutes coursework=1 contact hour.						
C2 Teaching/Lecture—MAX 5 hrs PT, 2 hrs PTA	Presentation of an original education program dealing with current research, clinical skills, procedures, treatment, or practice management related to the practice of PT principally for health care professionals. Must be accompanied by written materials prepared, augmented or updated by presenter. 60 minutes of instruction=2.5 contact hours.						
C3 Publication—MAX 5 hrs PT, 2 hrs PTA	Writing for professional publication, platform or poster presentation abstracts applicable to practice of PT. Credit may be earned for material that is a minimum of 1500 words and published by recognized 3rd party publisher.						
TOTALS							

MAKE SURE YOUR DOCUMENTATION INCLUDES DATE, PLACE, COURSE TITLE, COURSE SPONSOR, SCHEDULE, PRESENTER, NUMBER OF CONTACT HOURS RECEIVED FOR THE ACTIVITY AND PROOF OF COMPLETION.

PT/PTA Name: _____

License/Cert # _____

Date _____

CATEGORY C	Description of category activities below.				FOR AUDITOR USE ONLY		
Title of course, seminar, etc.	Date(s)	Contact Hours	CEUs Approved By	Documents Attached	Hours approved	Hours not approved	Reason for disapproval
C4 Clinical Instruction—MAX 5 hr PT 2 hr PTA	Clinical Instruction involves assisting a student PT or student PTA, PT resident or fellow acquire clinical skills. Individual receiving CI must be enrolled in a CAPTE accredited PT/PTA program or APTA approved residency/fellowship program. Each 120 hours of CI = 1 contact hour.						
TOTALS							

MAKE SURE YOUR DOCUMENTATION INCLUDES DATE, PLACE, COURSE TITLE, COURSE SPONSOR, SCHEDULE, PRESENTER, NUMBER OF CONTACT HOURS RECEIVED FOR THE ACTIVITY AND PROOF OF COMPLETION.