Request for Academic Records/Transcripts

PHYSICAL THERAPISTS

FOR APPLICANT TO COMPLETE BEFORE SENDING TO SCHOOL

My current name

First (given) name | Middle name | Last (family / surname) name

Name of school I attended

I attended between the dates of Month / Year and Month / Year

My birth date Month / Day / Year

My name when I attended this school

First (given) name | Middle name | Last (family / surname) name

My other names

My CGFNS ID number (if known)

My order number (if known)

Applicant signature

My current mailing address

Address

Address | City

State / Province | Post / Zip code | Country

Telephone number (include country code and area code) | Fax number (include country code and area code) | Email address

FOR SCHOOL TO COMPLETE

Dear Registrar:
Please complete this section of the form and send it to CGFNS along with the above applicant's academic records/transcripts listing the courses taken, hours of study and grades earned, *accompanied by a certified English translation.*

1. Applicant name

2. In what language was the applicant instructed? Applicant's birth date ____ / ____ / ____ Month / Day / Year

3. What was the textbook language for the applicant's program/course of study?

4. Program type (e.g., diploma, baccalaureate) Course of study

5. Attendance dates Month / Year to Month / Year Did applicant complete program ? ☐ Yes ☐ No

6. School name

7. School address

Address | City

State / Province | Post / Zip code | Country

SEAL OR STAMP

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PHYSICAL THERAPISTS

8. School telephone _____ School fax _____

9. School email address _____ School web address _____

10. Is this school accredited or government approved? ☐ Yes ☐ No

By whom? _____ Date accredited or approved ____ / ____ / ____ (Month / Day / Year)

Is this educational program accredited or government approved? ☐ Yes ☐ No

By whom? _____ Date accredited or approved ____ / ____ / ____ (Month / Day / Year)

I hereby attest that the enclosed academic records/transcripts accurately states the courses taken, hours of study and grades received for this applicant.

SEAL OR STAMP

11. Registrar signature _____ Date ____ / ____ / ____ (Month / Day / Year)

Do not print, sign entire name. **School seal or stamp must cover signature.**

Print name _____ Title _____

In addition to sending this form to your school requesting that they send it and a copy of your academic records/transcripts, in English, directly to ICHP, physical therapists must include with their application a self-reported summary of their supervised clinical experiences obtained during their physical therapy education with the following information. The summary must be in English.

Date of each supervised clinical experience	Hours/ weeks of each supervised clinical experience	Type of facility in which each supervised clinical experience took place (Inpatient, outpatient, other describe)	Overall focus of each supervised clinical experience (orthopedics, pediatric, geriatrics, medical-surgical)	Approximate number of patients cared for during supervised clinical experience	Age ranges of patients cared for during supervised clinical experience (0–18, 19–55, 56 and over)

If you need additional space, please use a separate sheet of paper and be sure to include your name.

Please send this document and academic records/transcripts, in English, in an envelope with your seal or stamp over the flap after sealing.
Send via airmail to : CGFNS International, 3600 Market Street, Suite 400, Philadelphia, PA 19104-2651 USA

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