

**APPLICATION FOR APPROVAL OF CONTINUING EDUCATION COURSE  
Individual Provider**

**Sponsor Name:** \_\_\_\_\_

**Contact Person:** \_\_\_\_\_

**Day Phone:** \_\_\_\_\_ **Alternate Phone:** \_\_\_\_\_

**Fax:** \_\_\_\_\_ **E-Mail:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Program Title:**

<b>Program Format:</b>	<input type="checkbox"/> Lecture/Lab <input type="checkbox"/> Video <input type="checkbox"/> Correspondence <input type="checkbox"/> Online <input type="checkbox"/> Other
<b>Key Word/Category:</b>	<input type="checkbox"/> Cardiopulmonary <input type="checkbox"/> Neuromuscular <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Integumentary <input type="checkbox"/> Pediatric <input type="checkbox"/> Women's Health <input type="checkbox"/> Management <input type="checkbox"/> Professional Issues <input type="checkbox"/> Other

**Date(s):** \_\_\_\_\_ **Location(s):** \_\_\_\_\_

**Speaker(s) Name(s), Title(s)** \_\_\_\_\_

**Intended Audience:**     PT     PTA     Students     Other (specify) \_\_\_\_\_

Has this program been approved for Continuing Education by another agency or association?

No     Yes (if yes please specify)

Date Approved \_\_\_\_\_ Agency \_\_\_\_\_

**Contact Hours:** (excluding meals and breaks) \_\_\_\_\_

The following information must accompany this application: (attach course brochure if inclusive of information listed below). Failure to include requested documentation may result in application being delayed or rejected.

1. Timed Outline or Agenda
2. Course Description
3. Course Objectives
4. Program Evaluation
5. Copy of Certificate of Completion
6. Home-study or online courses must submit a copy of the post-test and the minimum passing score and/or a certificate of completion
7. Biographical data for each speaker to include pertinent educational and clinical experience
8. Application fee of \$100
9. Include a self addressed, stamped envelope for reply

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Return to: **KPTA, 15847 Teal Road, Verona, KY, 41092, (859) 485-2812, FAX (859) 485-2813**

**Do not write below this line:**

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*For Office Use Only:*

\_\_\_\_\_ **Denied**    **Reason** \_\_\_\_\_

\_\_\_\_\_ **Approved**    **KPTA Approval #** \_\_\_\_\_ **Approval Expiration Date** \_\_\_\_\_  
*KPTA approval # and expiration date must be included on the course completion certificate*

**Approval Committee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

