

# NEVADA PHYSICAL THERAPY BOARD CCU VERIFICATION FORM

FOR **ADVANCED COMPETENCY** AND/OR **PROFESSIONAL ACTIVITY** ONLY

Please complete and return THIS PAGE along with the required documentation via licensure renewal

Licensee Name: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

**Advanced Competency Activity Type:**

- |  |   |
|--|---|
| <input type="checkbox"/> ABPTS Exam (See # 1)          | <input type="checkbox"/> In-Service (See #4)            |
| <input type="checkbox"/> Accredited Residency (See #2) | <input type="checkbox"/> Accredited Fellowship (See #2) |

**Professional Activity Type:**

- |   |   |
|---|---|
| <input type="checkbox"/> APTA NV /NPTB (See #4)               | <input type="checkbox"/> APTA NV/ NPTB Board/Committee Work |
| <input type="checkbox"/> College Coursework (See #4)          | <input type="checkbox"/> Pro-Bono PT Service (See #3)       |
| <input type="checkbox"/> Primary Clinical Instructor (See #4) | <input type="checkbox"/> Peer Reviewed Publication (See #5) |
| <input type="checkbox"/> Con Ed Course Instructor (See #4)    | <input type="checkbox"/> Mentorship                         |

Complete the following details as they apply to the activity type, please be as thorough as possible. For any questions/concerns, please contact the NPTB for clarification prior to submission.

**1. ABPTS Exam Specialty:** \_\_\_\_\_ **Exam date:** \_\_\_\_\_

**2. Residency/ Fellowship Program Name:**

\_\_\_\_\_

Contact Information: Program Director Name: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

**3. For Pro-Bono PT Service**– Please provide a brief description of how this activity is related to physicaltherapy:

\_\_\_\_\_

Contact Information: Supervisor Name: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Relevant Dates/Times: \_\_\_\_\_

**4. In-Service/Organization/Program/School Name/Course Instructor:** \_\_\_\_\_

Contact Information: Program Director Name: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Relevant Dates/Times: \_\_\_\_\_

**5. For Peer Reviewed Publication:** Licensee role in writing/publication process \_\_\_\_\_

Journal Article Title: \_\_\_\_\_

## NEVADA PHYSICAL THERAPY BOARD CCU VERIFICATION FORM

### 6. Mentorship Log

**Please complete the Mentorship log Below**

Mentor Name & License #: \_\_\_\_\_ Email: \_\_\_\_\_

Mentee Name	Date	Description of Mentorship Opportunity:	Duration (Minutes or Hours)	Mentee Signature

Total Time (hours): \_\_\_\_\_

CCUs (1 per 20hr Mentorship): \_\_\_\_\_

Mentor Signature: \_\_\_\_\_

Date: \_\_\_\_\_