

# APPLICATION FOR APPOINTMENT BOARD OF PHYSICAL THERAPY (PHYSICAL THERAPIST MEMBER)

**PLEASE PRINT OR TYPE**

**Name:** \_\_\_\_\_  
 First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ Credentials (ie, PhD, etc., if applicable) \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_  
 Street/Box/RR \_\_\_\_\_

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

Business Telephone \_\_\_\_\_ Cell/Pager \_\_\_\_\_ Residence Telephone \_\_\_\_\_

Email Address \_\_\_\_\_ FAX Number \_\_\_\_\_

Are you available to meet, usually in Lincoln, on a monthly basis, if necessary or required for Board Meetings? Yes  No

Please indicate how you became aware of this vacancy on this Board. Professional Association  DHHS Web Page

Newspaper  Other  (please explain) \_\_\_\_\_

|                                 |
|---------------------------------|
| <b>ELIGIBILITY REQUIREMENTS</b> |
|---------------------------------|

Do you hold a current Nebraska license to practice as a physical therapist? Yes  No  (Statutes require the physical therapist members of the board shall have held and maintained an active physical therapist license for a period of five years just preceding appointment and shall maintain such license while serving as a board member.)

Have you been actively engaged in practice as a physical therapist for the five (5) years just preceding this application? Yes  No  (Statutes require the physical therapist members of the board shall have been actively engaged in practice as a physical therapist for a period of five years just preceding appointment and shall maintain such practice while serving as a board member. Active practice means devoting a substantial portion of time to rendering professional services.)

Provide the number of years you have been engaged in the practice of physical therapy \_\_\_\_\_

Have you been a resident of the State of Nebraska for at least one (1) year? Yes  No  (Statutes require every member of the board shall have been a resident of Nebraska for one year and shall remain a resident of Nebraska while serving as a board member.)

|                  |
|------------------|
| <b>EDUCATION</b> |
|------------------|

| Degree/Specialty | School Name & Location | From  | To    | Completion Date |
|------------------|------------------------|-------|-------|-----------------|
| _____            | _____                  | _____ | _____ | _____           |
| _____            | _____                  | _____ | _____ | _____           |
| _____            | _____                  | _____ | _____ | _____           |
| _____            | _____                  | _____ | _____ | _____           |

**PLEASE COMPLETE REVERSE SIDE**

**DETAILED DESCRIPTION OF WORK EXPERIENCE AS A PHYSICAL THERAPIST  
WITHIN THE LAST FIVE YEARS IN NEBRASKA**

| Position Title | Name & Location | From  | To    | Average # of Hours/Week |
|----------------|-----------------|-------|-------|-------------------------|
| _____          | _____           | _____ | _____ | _____                   |
| _____          | _____           | _____ | _____ | _____                   |
| _____          | _____           | _____ | _____ | _____                   |
| _____          | _____           | _____ | _____ | _____                   |
| _____          | _____           | _____ | _____ | _____                   |

**ADDITIONAL INFORMATION**

Describe your interest in physical therapy and why you wish to serve on this Board.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you aware of any reason why your appointment might be considered a conflict of interest as defined in Title 172 NAC 3, Regulations Establishing Definitions of Conflicts of Interest for Members of the Boards of Examiners in the Health Professions?

Yes  No  If yes, explain.

\_\_\_\_\_

\_\_\_\_\_

Have you ever had your statutory ability to practice or clinical privileges suspended or revoked? Yes  No

Are you currently under investigation? Yes  No

Are you a veteran of the U.S. Armed Forces, or National Guard? Yes  No

If yes, is your military experience related to your current practice? Yes  No

I swear and affirm that all information I have provided on this application is true and complete to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Return completed Application to: Monica Gissler, State Board of Health,  
DHHS, Division of Public Health, Licensure Unit, P.O. Box 95026, Lincoln, NE 68509-5026  
402/471-6515; FAX 402/471-0383; monica.gissler@nebraska.gov**