

**ARKANSAS STATE BOARD OF PHYSICAL THERAPY**

**Application for Continuing Education Units**

**Sponsor Information**

Sponsored by: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Co-Sponsor: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Signature of person(s) authorized to sign course completion certificates: \_\_\_\_\_

Printed name of person(s) authorized to sign course completion certificates: \_\_\_\_\_

**Program Information**

Program Title: \_\_\_\_\_

Program Location: \_\_\_\_\_

Program Date(s): \_\_\_\_\_

Program Objectives: \_\_\_\_\_

Program Content: \_\_\_\_\_

Total Contact Hours (excluding breaks) \_\_\_\_\_

Attach course brochure or additional material showing a detailed schedule of course and specific objectives.

Mail, fax or email to:  
Arkansas State Board of Physical Therapy  
9 Shackleford Plaza, Suite 3  
Little Rock, AR 72211  
Fax: 501-228-0294 \* Email: arptb@sbcglobal.net

**BOARD USE ONLY**

Course approved by: \_\_\_\_\_ # of hours \_\_\_\_\_

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