Physical Therapy Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Board of Physical Therapy
Request for Spinal Manipulation Endorsement

Complete section one below and then forward to your clinical supervisor for completion of section two and three. This form may be duplicated if you have more than one clinical supervisor. You may not serve as your own clinical supervisor.

Applicant Demographics

First Name	Middle	Last Name

Credential # (if available)	Date of Birth

Email Address

If the email address currently on record with the Department of Health is different from the one provided above, would you like your address of record updated? ☐ Yes ☐ No

Education and Training

I have completed the following training as required under RCW 18.74.190 and WAC 246-915-381(1):

- ☐ One year of full-time, orthopedic, postgraduate practice experience that consists of direct patient care, averaging at least 36 hours a week; **and**
- ☐ Training in differential diagnosis of no less than 100 hours outlined within a course curriculum; **and**
- ☐ Didactic and practical training related to the delivery of spinal manipulative procedures of no less than 250 hours clearly delineated and outlined in a course curriculum; **and**
- ☐ Specific training in spinal diagnostic imaging of no less than 150 hours outlined in a course curriculum; **and**
- ☐ At least 300 hours of supervised clinical practical experience in spinal manipulative procedures.
- ☐ I completed these hours within 18 months of completing the last three items above; or, if I completed the last three items above before July 1, 2015 my clinical practical experience was completed by January 1, 2017.

Applicant Attestation

I declare under penalty of perjury under that laws of the state of Washington that the foregoing is true and correct. I understand that the Department may request additional information, if it is needed, to evaluate the application.

Signature ______________________________ Date ________________

To Be Completed By The Clinical Supervisor(s)

Please select the item that indicates how you qualify as a clinical supervisor in accordance with RCW 18.74.190 and WAC 246-915-381(1).

- ☐ Washington State Licensed Physical Therapist with a spinal manipulation endorsement.
- ☐ Licensed Chiropractor
- ☐ Licensed Osteopathic Physician and/or Surgeon

License Number ______________________________

Supervision of Applicant

I provided the applicant with supervised clinical practical experience in the amount of _________ hours.

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct. I understand that the Department may request additional information, if it is needed, to evaluate the application of the individual named on this document.

Clinical Supervisor Signature ______________________________ Date____________________

If the clinical supervisor has passed away, is incapacitated, or cannot be found, the applicant may submit an attestation/signed letter from another person with knowledge of the clinical supervisor's qualification, knowledge that the clinical supervision took place, and knowledge of how many hours were completed. Persons that might have this kind of knowledge may include the clinical supervisor's supervisor or manager, his or her successor, or the owner of the business where the supervision took place. If such a person cannot be found, the applicant may contact the program to determine if other evidence of supervision is sufficient.