PHYSICAL THERAPY COMMITTEE
AFFIRMATION OF SUPERVISION

State Form 52566 (3-06)

PHYSICAL THERAPY COMMITTEE
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2051
E-mail: pla6@pla.IN.gov

* Your Social Security number is requested by this agency in accordance with IC 4-1-8-1, and it is mandatory that it be given.

INSTRUCTIONS: *Applicants who are applying for a temporary permit to practice as a physical therapist or physical therapist assistant must have this supervision letter completed. This form must be completed in full and have an original signature by the licensed Indiana physical therapist who will be providing direct supervision. If this form is not completed in full, it will be mailed back to you. Faxed copies are not acceptable.*

"Direct supervision" means that the supervising physical therapist at all times shall be available and under all circumstances shall be absolutely responsible for the direction and the actions of the person supervised when services are performed by the holder of a temporary permit. Unless the supervising physical therapist is on the premises to provide constant supervision, the holder of a temporary permit shall meet with the physical therapist at least once each working day to review all patients' treatments.

APPLICANT INFORMATION	
Name of applicant (*last, first, middle, maiden*)	Social Security number *
Name of hospital / facility	Telephone number ( )
Address (*number and street or rural route, city, state and ZIP code*)	

SUPERVISOR INFORMATION	
Name of hospital / facility	Telephone number ( )
Address (*number and street or rural route, city, state and ZIP code*)	

TO BE COMPLETED BY SUPERVISOR

I hereby swear or affirm, under the penalties of perjury, that the applicant whose name appears above will be under my direct supervision while practicing physical therapy. According to IC 25-27-1-8 (d), 844 IAC 6-3-5, and 844 IAC 6-1-2 (e), I understand that I shall be available and under all circumstances shall be absolutely responsible for the direction and the actions of the person supervised when services are performed. I also understand that the patient's care shall always be my responsibility.

Signature of supervisor	Printed name of supervisor	Date signed (*month, day, year*)
Home address (*number and street or rural route, city, state and ZIP code*)		

Indiana license number	Date of expiration (*month, day, year*)	Date supervision is to begin (*month, day, year*)