NEVADA PHYSICAL THERAPY BOARD

3291 N. Buffalo Drive, Suite 100
Las Vegas, NV 89129
Phone: (702) 876-5535
Fax: (702) 876-2097

LICENSE REINSTATEMENT REQUEST

Please type or print clearly.

APPLICANT INFORMATION

Full Name: _____

License Number: _____

Mailing Address: _____

_____

Phone Number: _____

Email Address: _____

REQUEST FOR REINSTATEMENT

I request reinstatement of my expired Nevada physical therapist / physical therapist assistant license pursuant to NRS 640.150 and applicable Board regulations. I understand that reinstatement is at the discretion of the Board and that the Board may require additional information, payment of all required fees, proof of continuing competency, and attendance at a Board meeting, if requested.

Please describe the circumstances of the license expiration and the reason for this request:

_____

_____

_____

_____

_____

Renewal and Compliance Information

1. Date license expired: _____
2. Length of time expired:
3. Continuing competency documentation attached: ☐ Yes ☐ No
4. Other supporting documents attached: ☐ Yes ☐ No
5. Additional explanation, if needed:

Certification

I certify that the information provided in this request is true and correct to the best of my knowledge and that I understand the Board may request additional information or schedule a meeting before acting on this request.

Signature: _____

Printed Name: _____ Date: _____

BOARD USE ONLY

☐ Reinstatement approved: ☐ Reinstatement denied:

Board action date: _____

Authorized signature: _____

Title: _____ Date: _____

DRAFT