



Physical Therapy Practice Board  
 PO Box 47867  
 Olympia, WA 98504-7867  
 360.236.4700

**Board of Physical Therapy**

**Verification of Mentored Sharp Debridement  
 Education and Training**

This form may be duplicated. Fill out Section 1 and forward the verification form to the qualified provider for completion.

**1. Applicant** (print or type clearly)

Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_

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

**2. Approved Mentor**

The above individual seeks verification of mentored education and training to place a sharp debridement endorsement on his/her physical therapy license. Please complete the following:

Mentor Name \_\_\_\_\_ Current Phone \_\_\_\_\_

Current Street Address \_\_\_\_\_

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

Mentor's License Type and License Number \_\_\_\_\_ Date Licensed \_\_\_\_\_

**3. Mentored Education and Training Specific to Sharp Debridement**

A minimum of **twenty hours** of mentored sharp debridement and training is required. (Mentored training includes observation, co-treatment, and supervised treatment. Twenty hours mentored training in a clinical setting must include a case mix similar to the physical therapists' expected practice.)

Hours mentored \_\_\_\_\_ Describe the activities mentored \_\_\_\_\_

**Mentor**

I certify that the above information is, to the best of my knowledge, accurate and complete. I understand that the Department may request additional information, if it is needed, to evaluate the application of the individual named on this document.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Return this form to:**

Department of Health, Board of Physical Therapy, PO Box 47867, Olympia WA 98504-7867