



Washington State Department of  
**Health**  
 Board of Physical Therapy Credentialing  
 PO Box 47877  
 Olympia, WA 98504-7877  
 360.236.4700

## **Board of Physical Therapy Verification of Electroneuromyographic Training by a Qualified Provider**

Complete section one and forward the verification form to the qualified provider for completion.

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

Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_

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

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 my application.

### **2. Qualified Provider**

A qualified provider includes a physical therapist with board certification in clinical electrophysiology from the American Board of Physical Therapy Specialties, a neurologist, a psychiatrist, or a person who is board certified in clinical electrophysiology from the American Board of Physical Therapy Specialties.

The above individual seeks verification of training by a qualified provider to place an electroneuromyographic endorsement on his/her physical therapy license. Please complete the following:

Qualified Provider's Name \_\_\_\_\_ Current Phone \_\_\_\_\_

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

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

Provider's License Type and License Number \_\_\_\_\_

Dates Licensed \_\_\_\_\_

### **3. Education and Training**

A minimum of four hundred hours of electroneuromyographic training is required. Training includes at least two hundred needle EMG studies under direct supervision from a qualified provider.

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

### **Qualified Provider/Mentor**

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 my application.

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

**Return this form to the above address. This form may be duplicated.**