Physical Agent Modalities Practitioner Credentialing Agency, LLC
PAMPCA, LLC
4010 Ivy Drive, Nashville, TN 37216
615-414-8473

AFFIDAVIT AND RELEASE

Note: please scan these forms and send via email to: mcphee@pampca.org

I, _____, of _____, being
NAME CITY/STATE
and identified as the person referred to in this application, attests to the truth of such statement made in said application.

I HEREBY:

SIGNIFY, my willingness to appear to answer such questions as the PAMPCA, LLC, may find necessary which may include a PAMPCA Board of Directors interview.

RELEASE to the PAMPCA, LLC, its staff and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safety practice Occupational Therapy.

AUTHORIZE the PAMPCA, LLC, its staff and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualification, ability to work cooperatively with others and other qualifications;

RELEASE from liability the PAMPCA, LLC, its staff and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character and other qualifications for certification.

ACKNOWLEDGE that I, as an applicant for certification, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications and for resolving any doubts about such qualifications.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE DATE

Sworn to before me, this _____day of _____, 20_____ .

_____ Affix Seal Here
NOTARY PUBLIC

My Commission Expires:_____

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DOCUMENTATION OF CLINICAL APPLICATIONS
ELECTRICAL STIMULATION MODALITIES CERTIFICATION
Note: please scan these forms and send via email to: mcphee@pampca.org

NAME: _____ CREDENTIAL: OTR COTA

ADDRESS:_____ CITY/STATE/ZIP_____

License #:_____ State Issued:_____ Last 4 of SSN: XXX-XX-_____

DATE COMPLETED WORKSHOP:_____ LOCATION:_____

CLINICAL TREATMENTS COMPLETED (enter ***number*** performed; total of 10 required; one application per modality preferred but not required)

_____ Neuromuscular Electrical Stimulation

_____ Electrical Stimulation for Pain Control

_____ Electrical Stimulation for Edema Reduction

_____ Iontophoresis

_____ Other (describe procedure:_____)

_____ _____
Signature of Participant **Date**

I hereby certify that the above named individual has successfully completed the electrical modality treatments indicated and has demonstrated the safe, judicious application and documentation of same. Furthermore, by signing this form I certify and I am currently authorized to use physical agent modalities in the state indicated below.

_____ _____
Signature of Supervising Therapist **Date**

_____ _____
Printed Name of Supervising Therapist **Discipline**

_____ _____
License Number **State Issued**

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DOCUMENTATION OF CLINICAL APPLICATIONS
SUPERFICIAL AND DEEP THERMAL MODALITIES CERTIFICATION

Note: please scan these forms and send via email to: mcphee@pampca.org

NAME: _____ CREDENTIAL: OTR COTA

ADDRESS:_____ CITY/STATE/ZIP_____

License #:_____ State Issued:_____ Last 4 of SSN: XXX-XX-_____

DATE COMPLETED WORKSHOP:_____ LOCATION:_____

CLINICAL TREATMENTS COMPLETED (enter ***number*** performed; ***total of 10 required***, one application per modality preferred but not required)

_____ Superficial Heating Agents

_____ Cryotherapy

_____ Ultrasound

_____ Phonophoresis

_____ Other (describe procedure:_____)

_____ _____
Signature of Participant **Date**

I hereby certify that the above named individual has successfully completed the electrical modality treatments indicated and has demonstrated the safe, judicious application and documentation of same. Furthermore, by signing this form I certify and I am currently authorized to use physical agent modalities in the state indicated below.

_____ _____
Signature of Supervising Therapist **Date**

_____ _____
Printed Name of Supervising Therapist **Discipline**

_____ _____
License Number **State Issued**