PAMPCA, LLC
4010 Ivy Drive
Nashville, TN 37216
615-414-8473

PAMPCA
Physical Agent Modalities Practitioner Credentialing Agency, LLC

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 answer such questions as the PAMPCA, LLC, may find necessary in the application and by successful performance of all requirements for the conferral of the CPAM designation.
- **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 credentialing.
- **ACKNOWLEDGE** that I, as an applicant for credentialing, 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

To Be Completed by Notary Public:

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

_____ ***Affix Seal Here***
NOTARY PUBLIC

My Commission Expires: _____

NOTE: THIS FORM DOES NOT TAKE THE PLACE OF OFFICIAL STATE FORMS WHEN APPLYING TO YOUR STATE BOARD TO HAVE LICENSE AMENDED (WHERE REQUIRED).

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DOCUMENTATION OF SUPERVISED CLINICAL APPLICATIONS

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

Name:			
Credential: (circle one)	**OTR COTA Student Other**		
Last 4 of SSN	**XXX-XX-**		
Email Address:			
Address:			
City:		**State/Zip Code:**	
License #:		**State Issued:**	
Date 2 day Workshop Completed:		**Workshop Location:**	

CLINICAL TREATMENTS COMPLETED (10 Estim and 10 Thermal applications require – total of 20 applications required); enter ***number*** of applications performed; one application per modality preferred but not required)

Number	Electrical Stimulations
	Neuromuscular Electrical Stim
	TENS for Pain Control
	HVPS Stimulation
	Iontophoresis
	Other:

Number	Thermal Applications
	Superficial Heating Agents
	Cryotherapy
	Deep Thermal Agents (US, Diathermy)
	Laser
	Other:

_____ _____
Workshop Participant Signature **Date**

To be completed by the supervising therapist:
I hereby certify that the above-named individual has successfully completed the physical agent modality treatments indicated and has demonstrated the safe, efficacious application and documentation of same. Furthermore, by signing this form I certify that 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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