FCCPT 10 YEARS OF EXCELLENCE IN PT CREDENTIALING

SECOND REQUEST

10/24/2017

Physical Therapy Council
The Government Complex Commemorating His Majesty the King's 80th Birthday Anniversary
Building B, 2nd Floor, 120 Moo 3 Chaengwattana Road
Lak Si District, Bangkok 10210
Thailand

NYS Credential Verification PT

Dear Sir or Madam:

Ms. Manthana Phothisatean has applied to the New York State Education Department for licensure in the profession identified above. FCCPT has been requested to obtain her ***license/registration*** to practice directly from the issuing institution(s).

Enclosed you will find a request from **Ms. Manthana Phothisatean** to provide verification of her license to practice in **Thailand**. Please complete the attached "New York State Verification of License" form and send it to:

FCCPT
124 West Street South
3rd Floor
Alexandria, VA 22314-2825
USA

Thank you for your prompt attention to this request. Should you have any questions,

please contact us.

Sincerely,

Susan K. Lindeblad, PT, PhD.
Managing Director of FCCPT

FOREIGN CREDENTIALING COMMISSION ON PHYSICAL THERAPY, Inc
124 West Street South, 3rd Floor ■ Alexandria, VA 22314-2825
Telephone 703/684-8406 ■ Facsimile 703/684-8715 ■ Email www.fccpt.org

FCCPT
FOREIGN CREDENTIALING COMMISSION ON PHYSICAL THERAPY

New York State Credentials Verification
LICENSE/REGISTRATION VERIFICATION FORM

FOR LICENSING, REGISTERING, OR OTHER AUTHORITY TO COMPLETE AND SUBMIT TO FCCPT

Directions to Licensing/Registration Official: Please complete and send this form to:
FCCPT, 124 West Street South, 3rd Floor, Alexandria, VA 22314-2825

Should you have any questions please contact us at: ***Telephone, 703-684-8406; Fax, 703-684-8715; or E-mail, help@fccpt.org.***

Name of Licensing/Registration Authority: _____

Name/Title of Official Completing this form: _____

Institution Address: _____
Street City

_____
State/Province Post/Zip Code Country

Telephone: _____ Fax: _____ Email: _____

Applicant's Name: _____
(as licensed / registered)

The individual named above held/holds a license, is registered, or is otherwise authorized to practice physical therapy by the regulatory authority named above **from:** _____ **to:** _____
(MM/DD/YYYY) *(MM/DD/YYYY)*

Status of License/Registration: *(Check One)* ☐ Active/Current ☐ Expired ☐ Inactive ☐ Restricted*

* If the applicant's license to practice physical therapy has ever been revoked, suspended, limited, or placed on probation, please describe the reason below and/or attach documentation describing the reason for such action.

_____

_____

_____

Signature and Seal are required for completion of this form

I hereby attest that my responses are complete and accurate to the best of my knowledge. In witness whereof, I hereby set my hand and seal of this institution this _____ day of _____, 20_____.

Name of Official completing this form: _____
(Please Print)

Signature of Official completing this form: _____

(Affix Official Seal or Stamp)

October 24, 2017

FCCPT

New York State Credentials Verification
REQUEST FOR LICENSE/REGISTRATION VERIFICATION

Name:	Phothisatean	Manthana	-
	Last Name	First Name	Middle Name

Date of Birth:	Month: 07	Day: 16	Year: 1991	File Number: 43632

Name/Title of Recipient: P.T. Somjai Luewisetpaiboon

Name of Licencing Board or Registering Authority: Physical Therapy Council

Licensing Board Address: 120 Moo 3 Chaengwattana Road, Lak Si District
Street / City

Bangkok 10210 Thailand
State/Province Post/Zip Code Country

Applying to the New York State Education Department (NYSED) for licensure as a: Physical Therapy
Profession

The Foreign Credentialing Commission on Physical Therapy (FCCPT) has been authorized by the New York State Education Department to obtain and verify my licensure, registration, or other record indicating my eligibility to practice the profession stated above.

Please provide verification of my license/registration to practice within your state, country, or other jurisdiction, to FCCPT by COMPLETING THE ENCLOSED NEW YORK STATE LICENSE VERIFICATION FORM and submitting the completed form to:

Foreign Credentialing Commission on Physical Therapy
124 West Street South, 3rd Floor
Alexandria, Virginia 22314-2825

License Number: 7817

Date of Licensure/Registration*: 05/21/2013
(MM/DD/YYYY)
*If unsure of exact date, please enter attendance YEAR, at a minimum.

Name when license was issued: Phothisatean Manthana -
(if different from name above) Last First Middle

Home Phone: +1 845-589-3462 Work Phone: -
(include Country and Area/City Code for Home and Work)

Email: manthana42@gmail.com

I hereby authorize the release of my licensure, registration, or other records indicating my eligibility to practice within your country, state, or other jurisdiction, to the Foreign Credentialing Commission on Physical Therapy (FCCPT).

Manthana Phothisatean 10/17/17
Applicant Signature Date

LICENSING AUTHORITY: PLEASE COMPLETE THE ENCLOSED NEW YORK STATE LICENSE/REGISTRATION VERIFICATION AND SUBMIT TO FCCPT.