MARYLAND
Department of Health

MARYLAND BOARD OF PHYSICAL THERAPY EXAMINERS

4201 PATTERSON AVE.
BALTIMORE, MARYLAND 21215-2299
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www.dhmh/maryland.gov/bphte

OFFICE USE			
Date Received	______	Date Reviewed	______
Reviewed By	______	Date Entered	______
Meets Requirements	____ Yes	____ No	

DRY NEEDLING REGISTRATION APPLICATION

Under COMAR 10.38.12 a physical therapist who wishes to practice dry needling in The State of Maryland must meet certain education and training requirements and be registered prior to practicing. It is the responsibility of the physical therapist to read and understand the regulations prior to applying for registration.

To register with the Board please complete this application either on-line or by hand with **BLACK** ink. The physical therapist who oversaw your hands-on training **MUST** complete the certification section stating you met the hands-on requirements. Once you have completed the application send it along with copies of the certificates of completion for each course. You may mail the completed application to the address above or email to **MDH.DryNeedling@Maryland.Gov**

If you do not have a certificate of completion for an educational course you **MUST** complete the course description section of the application.

Once the Board reviews the completed registration application and attached documents you will be notified if the minimum education and training requirements have been met. You may not practice until you have received written approval from the Board. If your application is denied you will be receive a written notice stating why. Notices will be send by either email or a formal letter. The Board will not review incomplete registration applications.

PHYSICAL THERAPIST

Please print or type all information

Name: ______________ (Last) ______________ (First) ______________ (Middle)

Date of Birth: ______________ **MD License #:** __________ **E-Mail:** ______________

Home Address: ______________ (Street) (City) (State) (Zip)

Home Phone: ______________ **Cell Phone:** ______________ **Work Phone:** ______________

Are you an active duty member of the U.S. Military? _____ **Yes** _____ **No**

Are you the spouse of an active duty military member? _____ **Yes** _____ **No**

Branch: ______________________________

Duty Station: ______________________________

CLASSROOM INSTRUCTION

Please print or type all information. If you have more than one course please make copies of this page and include them with the application. You must provide a detailed description of the course to be reviewed by the Board. The description **MUST** include all information pertinent to **COMAR 10.38.12.03 A** – Minimal Education and Training Required. This section is not necessary if you have a certificate of completion for a course.

Course : ______________________________ **Hrs. or CEU's** __________

Date: __________ **Location:** ______________________________
(City/State)

Sponsor: ______________________________

Description: (Detailed)

HANDS ON TRAINING CERTIFICATION

This section must be completed by the licensed health care practitioner competent in dry needling procedures who oversaw your required 40 hours of hands-on instruction. If more than one health care practitioner oversaw your training then each must complete this section. Please make as many copies as needed and include them with your application.

Therapist: ______________________ **License #:** ________________ **Hrs. Supervised** ____________
(Supervising Therapist)

Contact #: __________________ **E-Mail:** ____

I do hereby attest and certify that I have five years of experience performing dry needling and that I personally supervised **Trainee:** ________________________________ **License #** __________________

in the practical hands-on instruction in the application and techniques of dry needling as required under COMAR 10.38.12.03 A (2) for the hours indicated above.

________________________________ ________________
(Signature) *(Date)*

ATTESTMENT

I hereby submit the Dry Needling Registration Application to the Maryland Board of Physical Therapy Examiners and, **I HEREBY DECLARE AND AFFIRM** under the penalties of perjury that the maters and information contain in this application are true and correct to the best of my knowledge, information and belief.

______________________________ **Date**

______________________________ **Signature**

AFFIDAVIT

State of: ______________________________

City/County of: ______________________________

Before the undersigned, a Notary Public in and for the city/County and state aforesaid, on the

________ day of ______________ 20 ____ , Personally appeared ______________________

Who, being first duly sworn, says he/she is the person referred to herein, and is the person who signed the foregoing application; that the facts and statements contained are true, to the best of his/her knowledge and belief.

____
Notary Public *(signature)*

Notary Stamp Here

My Commission expires: ______________
MM/DD/YYYY