



Reprocess an Expired ICD Evaluation of Physical Therapy Credentials Application

Provide all information requested below. Use a typewriter or print legibly in ink.

1 ICD Preliminary information

- a. Have you ever applied to ICD before? Yes No
- b. If yes, please provide your ICD file number _____ Date _____
- c. How did you learn of this service? U.S. College/University State Licensure Board Recruiter
 U.S. Employer Immigration Attorney Internet Other _____
- d. Why did you select ICD over another organization for your credentials evaluation? ICD's reputation
 Instructed by your report recipient Price Other _____

2 Your name

Print or type your full name as you would like it to appear on all correspondence. Put only one letter in each box.

Given (first) and middle names (Leave a blank square between names)

Surname (last/family name) (Leave a blank square between names)

3 Your other names

List alternate names appearing on your documents. Include legal documentation/evidence verifying name change.

Name before marriage _____

Other name _____

4 Your birth date (Spell the month and enter numbers for day and year)

Month _____ Day _____ Year _____

5 Your gender

- Female
- Male

6 Your U.S. Social Security Number (if known)

7 Your contact details

Print or type the address where ICD should mail all correspondence to you.

Address _____

Address _____

City _____

State/Province _____ Post code _____ Country _____

Telephone (include country code) _____ Fax (include country code) _____

Email _____

11 Report recipients

Indicate here the names and addresses of as many as **two** different recipients for your report. Enter the contact details of the state where you need to be evaluated for licensure that you list in Item 12 below. **Note:** If you would like to receive a copy of the report for yourself, please list your name as one of the recipients.

Name and address of first report recipient	Name and address of second report recipient
Name	Name
Address	Address
Address	Address
City	City
Country, Post code	Country, Post code

12 Fees for ICD credentials evaluation reports

Please confirm the report type needed with your recipient(s) before completing this application.

Indicate the state(s) where you need to be evaluated for licensure. The fee for an ICD report is for one state. Add the fee for each state you need a report for, and for any additional services, and submit the total.

ICD will not provide copies or perform a re-evaluation on documents in our possession greater than three years old. If your original evaluation was completed over three years ago, please complete a new application including academic and registration/license forms. Since most state boards require original academic records/transcripts be mailed directly to them from your school, the process will go much faster if you request academic records/transcripts be mailed to both ICD and to the state board(s) now.

Check to indicate selection (Check all that apply)

Individual state forms

	Total fees due
<input type="checkbox"/> Florida \$160.00	\$.
<input type="checkbox"/> Kansas \$170.00	\$.
<input type="checkbox"/> Tennessee (includes proof of English Language proficiency) \$165.00	\$.
<input type="checkbox"/> Re-evaluation (by state) FULL FEE	\$.

Multi-state forms

<input type="checkbox"/> Guam, Montana, Puerto Rico (each) \$75.00	\$.
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Detailed coursework evaluation tool states

<input type="checkbox"/> Arizona, Arkansas, California, Colorado, Delaware, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Maine, Maryland, Michigan, Mississippi, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, Ohio, Oregon, South Carolina, Texas, Virginia, Washington, Wisconsin, Wyoming (each) \$140.00	\$.
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Priority service for services listed above, per state

<input type="checkbox"/> 14 Day* Priority Service** (optional) \$100.00	+ \$.
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Fees for additional services (Check all that apply)

<input type="checkbox"/> Each additional state at time of initial application \$ 100.00	+ \$.
<input type="checkbox"/> Additional report recipient (state boards cannot be additional recipients) \$ 25.00	+ \$.
<input type="checkbox"/> Overnight courier, Domestic \$ 40.00	+ \$.
<input type="checkbox"/> Overnight courier, International \$ 75.00	+ \$.
<input type="checkbox"/> Originals returned by courier \$ 25.00	+ \$.
<input type="checkbox"/> Document translation (per page) \$ 75.00	+ \$.
total	\$.

* business days

** In order to ensure efficient service, ICD reserves the right to limit the number of priority service requests to be processed at a given time. If you are requesting priority service, you may want to include the additional overnight courier service to mail your report to the recipient(s).

Full payment for all services requested must be included with your application. Send only a certified bank check or international money order, drawn in U.S. dollars on a U.S. bank, and made payable to ICD, or pay by credit card using the *Credit Card Payment Form* on page 9.

13 Terms and Conditions of the International Consultants of Delaware credentials evaluation

The following clarifies the obligations of the provider (ICD) and the applicant (you) of the ICD credentials evaluation, as well as the manner in which this service is delivered.

- ICD reserves the right to evaluate any material it deems applicable to the ICD credentials evaluation application.
- No evaluation is conducted until a completed application and full payment is received by ICD.
- Applications remain open for 12 months. Applicants who do not meet the requirements of the ICD Credentials Evaluation application within the first 12 months of their order may continue the service by applying to reprocess and paying the associated fee.
- Fees, as published with this application, are subject to change and are non-refundable, except in the case of overpayment.

ICD's evaluations provide assistance in understanding foreign educational credentials by comparing them to the U.S. educational system. ICD's opinions are strictly advisory and recipients of ICD evaluations make their own decisions and interpretations based on the information provided in the evaluation.

14 Attestation

Please note: Each applicant must sign his/her full name in English on the applicant's signature line. Do not submit this application unless you understand and agree to the following terms:

I agree to the Terms and Conditions of the International Consultants of Delaware credentials evaluation as outlined in Item 13 (above).

I certify that all information which ICD has received as a part of this application or in the past, from me or from a third party on my behalf, is true and complete. I certify that all documents which have been submitted to ICD for any purpose have not been falsified, altered or tampered with by any person.

I understand that ICD and others will rely on this application and on the documents and information submitted, and that if any of it is falsified, altered or tampered with, or if I alter an ICD credentials evaluation Report or misrepresent a copy as an original, ICD may take such disciplinary action against me as it deems appropriate, and the consequences could adversely affect my professional license, immigration status, employment, and other matters, from which I release ICD from all liability.

I release ICD from any liability for damages resulting from the use of a Credentials Evaluation Report, and agree to reimburse ICD for any and all costs, including legal expenses, which ICD may incur as a result of any claim I (or anyone having an interest in my earnings or services) may make, based upon the evaluation determination. Further, I release ICD from any liability for the loss or damage to documents submitted with respect to an application for an evaluation.

I authorize ICD to contact any relevant institutions for verification purposes, and to request any additional information needed prior to completing the evaluation, and to disclose the information and documents in this application, the status of any reports, verifications or evaluations prepared by ICD, any other information obtained by ICD, and the results and reasons for any adverse action taken against me by ICD to any person or organization I designate in writing or to any other recipient which ICD may determine has a legitimate interest in receiving the same, such as government agencies and potential employers.

You *must* sign and date this application in order for it to be processed.

Applicant signature (do not print)

Date

