

**Physical Agent Modalities Practitioner Credentialing Agency, LLC
PAMPCA, LLC
1002 Stratton Road
Ashland City, TN 37015
615-414-8473**

**DOCUMENTATION OF CLINICAL APPLICATIONS
ELECTRICAL STIMULATION MODALITIES CERTIFICATION**

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

**Physical Agent Modalities Practitioner Credentialing Agency, LLC
PAMPCA, LLC
1002 Stratton Road
Ashland City, TN 37015
615-414-8473**

**DOCUMENTATION OF CLINICAL APPLICATIONS
SUPERFICIAL AND DEEP THERMAL MODALITIES CERTIFICATION**

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