



COUNCIL of LICENSED PHYSIOTHERAPISTS of NEW YORK STATE, Inc.

*Physical Therapy Association
of New York State Inc.*

*Physiotherapists of Central
New York State, Inc.*

*New York State Society
Physiotherapists, Inc.*

*Northeastern Society of
Licensed Physiotherapists*

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(718) 875-3167

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(516) 367-1111

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Woodmere, NY 11598
(516) 374-6822

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Rains, Pogrebin
Rains Building
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37 Bellewood Avenue
Centerreach, NY 11720
(631) 981-6021

NEW MEMBER APPLICATION

Name _____ Phone _____

Office _____

Mailing Address _____

E-mail _____ Fax _____

License Number _____ Date Issued _____

Colleges Attended _____

Degrees held; dates _____

Membership in professional organizations _____

Are you a Physical Therapist owned practice? Yes _____ No _____

Does any other party other than the therapist listed above have ownership in or
conduct management service for this practice? Yes _____ No _____

I hereby certify that all answers are true and accurate and agree, in the event that
at any time I fail to abide by the Constitution and By-Laws, Rules and
Regulations and Code of Ethics, I forfeit my membership in the Council.

Dated _____ Signed _____

Recommended by _____

To receive consideration, this application must be returned to the Treasurer with
all payment and dues, card and/or letterhead or other printed matter connected
with your practice.

Treasurer: Allen Bistrong, PT, 142 Joralemon Street
Suite 11A, Brooklyn, NY 11201

Contact: Rosalie Bistrong, (718) 875-3167

Please make check payable to Council of Licensed Physiotherapists of NYS in
the amount of \$375 for the first years' dues. Thank you.

Membership Committee: Accepted _____ Rejected _____ Date _____