

PROFESSIONAL PORTFOLIO OF: _____ # _____

PRINT name and CPTNB Reg #

**Complete and include this checklist with your portfolio
and put the corresponding # on each document.**

2024 Portfolio	YES ✓	NO ✓	Comments (optional)
I. Evidence of minimum requirements such as:			
1. An updated, résumé/curriculum vitae (CV)	<input type="checkbox"/>	<input type="checkbox"/>	
2. Job and/or Practice Setting Descriptions	<input type="checkbox"/>	<input type="checkbox"/>	
3. Performance Appraisals and Reference letters	<input type="checkbox"/>	<input type="checkbox"/>	
4. Copies – current only (2024/25)			
i. CPTNB Licence	<input type="checkbox"/>	<input type="checkbox"/>	
ii. Professional Liability Insurance Policy	<input type="checkbox"/>	<input type="checkbox"/>	
5. Credentials/Evidence of:			
i. Physiotherapy degree(s)	<input type="checkbox"/>	<input type="checkbox"/>	
ii. Other formal education (e.g. PCE)	<input type="checkbox"/>	<input type="checkbox"/>	
6. Evidence of qualifications re (pre-approved by CPTNB) sub-registers, if relevant:			
i. Acupuncture-Dry Needling	<input type="checkbox"/>	<input type="checkbox"/>	
ii. Specialty Certifications	<input type="checkbox"/>	<input type="checkbox"/>	
Only check YES if items #7-10 are dated from 2019-2024. If older, check NO			
7. Record/log of other relevant professional development/continuing education:			
i. Courses/Workshops	<input type="checkbox"/>	<input type="checkbox"/>	
ii. Presentations/Surveys Developed or Completed	<input type="checkbox"/>	<input type="checkbox"/>	
iii. Physiotherapy Reading/Research	<input type="checkbox"/>	<input type="checkbox"/>	
iv. In-Services/PT health Committees/Projects	<input type="checkbox"/>	<input type="checkbox"/>	
v. Chart Audit Reviews	<input type="checkbox"/>	<input type="checkbox"/>	
8. Documentation (e.g. certificates) indicating participation/involvement in:			
i. Courses/Workshops	<input type="checkbox"/>	<input type="checkbox"/>	
ii. Presentations/Surveys	<input type="checkbox"/>	<input type="checkbox"/>	
iii. Supervision/Monitoring of Others	<input type="checkbox"/>	<input type="checkbox"/>	
iv. Regulatory or Association Roles	<input type="checkbox"/>	<input type="checkbox"/>	
II. Evidence of more advanced components such as:			
9. Learning Plan or Goals/Needs	<input type="checkbox"/>	<input type="checkbox"/>	
10. Self-reflection Components			
i. Practice Self-Assessments	<input type="checkbox"/>	<input type="checkbox"/>	
ii. Patient Care Reflection	<input type="checkbox"/>	<input type="checkbox"/>	
iii. Critical Incident(s) Reflection	<input type="checkbox"/>	<input type="checkbox"/>	

Signature: _____ Date: _____

MM/DD/YY