



**Section II: Verification of Licensure/Certification: (Please print or type)**

**Instructions to the Licensing/Certifying Authority:** Please complete items 1-4, sign and date the certification and return both pages of this form in an official envelope directly to the Office of the Professions at the address below. This form will not be accepted if returned by the applicant. Attach additional sheets if necessary.

**1** Name of applicant: \_\_\_\_\_  
(Section I, item 6)

**2** Professional title on license/certificate: \_\_\_\_\_  
License/certificate number: \_\_\_\_\_ Date of licensure/certification: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

**3** Verification of licensure/certification  
What requirements did the applicant meet to become licensed/certified in your jurisdiction?  
Education: Degree: \_\_\_\_\_  
Examination: Title: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Score: \_\_\_\_\_  
mo. day yr.  
Experience:  None  \_\_\_\_\_ hours Describe (i.e., clock hours) \_\_\_\_\_  
 Endorsement of license from or reciprocity with \_\_\_\_\_  
(name of jurisdiction)  
 Grandparented

**4** A. Has the applicant identified in Section I been subject to any disciplinary action?  Yes  No  
B. Are any charges pending against this individual?  Yes  No  
**If the answer to either of these questions is "yes," please attach a complete explanation with any supporting documentation.**

**Certification**

I hereby certify that to the best of my knowledge and belief the foregoing is a true statement of the record of the applicant named on this form. I further certify that, except as noted in item 4 above or in any attachments, this licensing/certifying authority has never taken any disciplinary action against this person and that in so far as the licensing/certifying authority has knowledge, there have been no charges preferred nor has any information been presented relating to any question of unprofessional or immoral conduct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.  
Print name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Licensing/certifying authority: \_\_\_\_\_ **(SEAL)**  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_

**Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Clinical Laboratory Technology Unit, 89 Washington Avenue, Albany, NY 12234-1000.**