

# APPLICATION FOR CERTIFICATION TO USE ACUPUNCTURE

Applicants Must Complete Both Pages Of This Application ***In Ink***

### Applicant Instructions

All applicants for certification must complete this form in ink and submit it with the \$150 certification fee directly to the Office of the Professions at the mailing address at the end of this form. You must answer all questions and provide all information requested unless otherwise indicated. Failure to complete all required parts of the application will delay its review. Your signature on this form must be notarized by a Notary Public.

**1 Check what you are applying for:**

Dentistry	<input type="checkbox"/>	50	\$150	AC
Medicine	<input type="checkbox"/>	60	\$150	AC

**2 Social Security Number**

(Leave this blank if you do not have a U.S. Social Security Number)

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**3 Birth Date**

Month 

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 Day 

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 Year 

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**4 Print Your Name Exactly As It Appears On Your Medical or Dental License**

Last 

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First 

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Middle 

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**5 Mailing Address** (You must notify the Department promptly of any address or name changes.)

Line 1 

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Line 2 

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Line 3 

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City 

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State 

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 Zip Code 

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Country/Province 

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**NYS License Number**

**6 Telephone/E-Mail Address**

**Daytime Phone**

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Area Code Phone Number

**E-Mail Address** (Please print clearly)

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**7 New York State DMV ID Number**  
(Driver or Non-Driver ID)

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(Leave this blank if you do not have a New York State DMV ID Number)

**8** New York State profession license number: \_\_\_\_\_

**9** Have you previously applied for a New York State certificate to use acupuncture?  YES  NO

**10** List **Non-Registered** New York State Acupuncture Programs completed.

Program Sponsor: \_\_\_\_\_ Hours of Instruction: \_\_\_\_\_

Location of Program: \_\_\_\_\_ Date of Program: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mo. day yr.

Program Sponsor: \_\_\_\_\_ Hours of Instruction: \_\_\_\_\_

Location of Program: \_\_\_\_\_ Date of Program: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mo. day yr.

Program Sponsor: \_\_\_\_\_ Hours of Instruction: \_\_\_\_\_

Location of Program: \_\_\_\_\_ Date of Program: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mo. day yr.

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List **Registered** New York State Acupuncture Programs completed.

Program Sponsor: \_\_\_\_\_ Hours of Instruction: \_\_\_\_\_

Location of Program: \_\_\_\_\_ Date of Program: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mo. day yr.

Program Sponsor: \_\_\_\_\_ Hours of Instruction: \_\_\_\_\_

Location of Program: \_\_\_\_\_ Date of Program: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mo. day yr.

Program Sponsor: \_\_\_\_\_ Hours of Instruction: \_\_\_\_\_

Location of Program: \_\_\_\_\_ Date of Program: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mo. day yr.

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**AFFIDAVIT WITH ACKNOWLEDGMENT** (Notarization required.)

**APPLICANT**

I declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of licensure and may result in criminal prosecution.

Signature of the applicant: \_\_\_\_\_

**NOTARY**

State of \_\_\_\_\_ County of \_\_\_\_\_

On the \_\_\_\_\_ day of \_\_\_\_\_ in the year \_\_\_\_\_ before me, the undersigned, personally appeared \_\_\_\_\_, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public signature \_\_\_\_\_

Notary ID number \_\_\_\_\_

Expiration date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Month Day Year

Notary Stamp

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, PO Box 22063, Albany, NY 12201. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.