FORM 2AC

ACUPUNCTURE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

CERTIFICATION OF ACUPUNCTURE EDUCATION

APPLICANT INSTRUCTIONS

1. Complete Section I. Enter your name as it appears on your New York State Application for Certification to use Acupuncture (Form 1ACR). Be sure to sign and date item 9.
2. Send this form to the professional school you attended to complete Section II. Be sure to include any fee required. If the program you completed was not registered by New York State, notify the school that a transcript must accompany this form.
3. This form must be signed by the Registrar or Program Director of the school and sent back directly to the Office of the Professions by that school official in an official school envelope to the address at the end of this form. Forms sent back by the applicant or other parties will not be accepted. If you attended more than one program, a Form 2AC must be submitted for each completed program.

SECTION I: APPLICANT INFORMATION

1 SOCIAL SECURITY NUMBER ☐☐☐ ☐☐ ☐☐☐☐

(Leave this blank if you have no U.S. Social Security Number)

2 BIRTH DATE ☐☐ ☐☐ ☐☐ *Month Day Year*

3 PRINT FULL NAME EXACTLY AS IT APPEARS ON YOUR APPLICATION FOR CERTIFICATION TO USE ACUPUNCTURE (FORM 1ACR)

Last
First
Middle

4 MAILING ADDRESS:

Apt./Bldg.
Street
City
State Zip Code
Province/Country If not U.S.

5 **TELEPHONE/E-MAIL**

Daytime Phone ☐☐☐ ☐☐☐ ☐☐☐☐ *Area Code Number*

_____ *E-Mail Address*

6 Print name under which your acupuncture credential was awarded *(if different from above)* : _____

7 Professional school attended: _____

Address: _____

8 Program title: _____ Hours completed: _____ Date completed _____ / _____ / _____ mo. day yr.

9 I request and give my permission to the school listed in item 7 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for certification.

Applicant's signature: _____ Date: _____ / _____ / _____ mo. day yr.

SECTION II : CERTIFICATION OF ACUPUNCTURE EDUCATION

INSTRUCTION TO SCHOOL: Please complete Part A or Part B of this section, sign the certifying statement, attach any additional information required (if applicable) and send this form directly to the Office of the Professions at the address shown below. **This form will not be accepted if returned by the applicant or any other party.**

Name of applicant _____
(Item 6, Section I)

A. New York State Registered/Approved Acupuncture Programs:

The above named applicant has completed the following programs registered by the New York State Education Department as qualifying for credit toward the 300 hours of acupuncture training required for certification to use acupuncture.

Program title: _____

All program requirements were met on: _____ / _____ / _____ Acupuncture credential was awarded on: _____ / _____ / _____
mo. day yr. mo. day yr.

Date	Title of Program	Hours of Credit

B. Non New York State Registered/Approved Acupuncture Program (Attach transcript showing content and hours):

The above named applicant has completed the following program not registered by the New York State Education Department as preparation for the practice of acupuncture.

Program title: _____

The program contained _____ hours of classroom work The program contained _____ hours of supervised clinical training

Date of admission: _____ / _____ / _____ Date of Completion: _____ / _____ / _____
mo. day yr. mo. day yr.

Credential Awarded: _____ Date: _____ / _____ / _____
mo. day yr.

This program was approved by: _____

CERTIFICATION

I certify that to the best of my knowledge and belief the foregoing is a true statement of the record of the individual named on this form.

Signature: _____ *Date:* _____ / _____ / _____

Type or print name: _____

Title: _____

School: _____ **(SEAL)**

Address: _____

_____

Telephone: _____ *Fax* _____

E-mail address: _____

CERTIFICATION IS NOT ACCEPTABLE UNLESS DATED AFTER GRADUATION.

Return this form Directly to: →	New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Medicine Board, 89 Washington Avenue, Albany, NY 12234-1000.