Affidavit of Non-Compensation

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Name Last

First

Middle

Mailing Address:

☐ **Home** ☐ **Business**

Note: Licensee business address, phone and e-mail address are public information. Failure to indicate business or home on this form for each item will deem it public information.

Line 1

Line 2

Line 3

City

State Zip Code

Country/ Province

Physician License Number:

I am applying for a waiver of the fee for the registration of my license as a physician in the State of New York under the provisions of Section 6524(10) of the New York State Education Law for the registration period ending: _____ / _____.
mo. yr.

This law allows a waiver of the registration fee requirement for physicians who certify to the State Education Department that, for the period of their registration, they will only practice medicine without compensation or the expectation or promise of compensation. The waiver of the registration fee is limited to the duration of the registration period indicated herein. In consideration for that waiver, I affirm and agree to the following during the full registration period for which a waiver is granted:

1. I understand the above requirement for a waiver and to obtain this waiver I agree to practice medicine in New York without compensation or the expectation of compensation in accordance with Section 6524 (10) of the New York State Education Law.
2. I am not and will not be a shareholder, officer, director, member or manager of a Professional Corporation (PC), Professional Limited Liability Company (PLLC), or a Limited Liability Partnership (LLP). Or, if I am a shareholder, officer, director, member or manager of a PC, PLLC or LLP, that I have attached documentation that verifies that I am not being compensated for the practice of medicine by these business entities.
3. I understand that the fee waiver associated with this registration is valid only for the registration period specified above. If I seek to continue to practice medicine after the above registration period is ended, I must renew my registration and if I desire a waiver for the next registration period I must file a new affidavit.
4. To notify the New York State Education Department in writing at the address at the bottom of this page within 30 calendar days of any change in my compensation status that could affect my eligibility for this registration fee waiver.

Affirmation

I affirm that the information provided herein and submitted herewith is true, complete and correct and that this information will be for all purposes the equivalent of an affidavit and if it contains a false statement, shall subject me to the same penalties for perjury as if I had been duly sworn.

_____ _____
Signature Date

Subscribed and sworn before me this _____ day of _____ 20 _____

Notary Public: _____

Notary Stamp

Notary ID Number: _____ Expiration Date: _____ / _____ / _____
mo. day yr.

Return this Affidavit with your registration application form to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Fee Unit, 89 Washington Avenue, Albany, New York 12234-1000