Post Medical School Activity Record Form

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

Post Medical School Activity Record

Instructions: Please complete this form and return it to the Office of the Professions at the address at the end of the form. Your signature **must** be notarized by a Notary Public.

1 **Social Security Number** ☐☐☐ ☐☐ ☐☐☐☐

2 **Birth Date** Month ☐☐ Day ☐☐ Year ☐☐

3 **Print Name**

Last

First

Middle

4 **Mailing Address** *(you **must** notify the Department promptly of **any** address or name changes using the Address/Name Change Form which can be found on our Web site at www.op.nysed.gov/anchange.pdf.)*

Line 1

Line 2

Line 3

City

State ☐☐ Zip Code ☐☐☐☐☐ ☐☐☐☐

Country/ Province

5 **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. **This form must be signed and dated in the presence of a Notary Public.**

Signature of the applicant: _____

Date _____ / _____ / _____
Month Day Year

Notary

State of _____ County of _____

On the _____ day of _____ in the year _____ before me, the above signed, personally appeared

_____, personally known to me or proved to me on the basis of satisfactory evidence
Applicant Name

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

6 Provide a chronological list of all activities since graduation from medical school to the present. Include vacation periods of employment. Attach additional sheets if necessary.

Date graduated medical school: _____ / _____
Month *Year*

Date (mm/yy)		Type of activity, beginning with date of graduation from medical school, to the present including residency. Include name and address of employers. **Please be sure not to leave any gaps in time.**
From	To	