FORM 4

CHIROPRACTIC

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

ALL ENDORSEMENT APPLICANTS MUST COMPLETE THIS FORM

VERIFICATION OF EXPERIENCE

APPLICANT INSTRUCTIONS

1. Complete Section 1. Enter your name as it appears on your Licensure Application (Form 1). Be sure to sign and date item 7.
2. Send this form to a licensed professional colleague to complete Section II and send directly to the Office of the Professions at the address at the end of this form.

NOTE: **A separate Form 4 must be received by the Department from each of two licensed colleagues. You must use separate forms for each verification.**

SECTION I: APPLICANT INFORMATION

1 SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐

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

2 BIRTH DATE ☐☐ ☐☐ ☐☐
Month Day Year

3 PRINT YOUR FULL NAME EXACTLY AS IT APPEARS ON YOUR LICENSURE APPLICATION (FORM 1)

Last

First

Middle

4 MAILING ADDRESS (You must notify the Department promptly of any address or name changes.)

Line 1

Line 2

Line 3

City

State

Zip Code

Country/ Province

5 **DATE OF LICENSURE:** ☐☐ ☐☐ ☐☐
Month Day Year

In which state, province or country? ______________________________

6 **PRACTICE EXPERIENCE**

Name of practice: ______________________________

Practice address: ______________________________

____

Dates of practice: From _____ / _____ To _____ / _____ . (Period must represent at least two of the immediate past five years.)
Mo. Yr. Mo. Yr.

7 **ATTESTATION**

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 applicant: ______________________________ *Date:* _______ / ________ / _______
mo. day yr.

SECTION II : VERIFICATION OF EXPERIENCE (Please Print All Information)

INSTRUCTIONS TO LICENSED PROFESSIONAL COLLEAGUE COMPLETING SECTION II: Please complete Section II and sign and date the attestation. This form must be returned **directly** to the Office of the Professions. This form will not be accepted if returned by the applicant.

1) Name of applicant: _____ _____ _____
First *Middle* *Last*

2) Your professional relationship to applicant: _____

3) Applicant was in practice: from _____ 19 _____ to _____ 19 _____ .

4) Name and address of practice setting: _____

_____

5) Describe applicant's Chiropractic practice experience: _____

_____

_____

_____

_____

6) Other comments: _____

_____

_____

_____

ATTESTATION

I declare and affirm that the statements above are true, complete and correct.

Signature of licensed professional colleague : _____ Date: _____ / _____ / _____
mo. day yr.

Print name: _____

Professional title: _____

License number: _____ State: _____

Address: _____

_____

Telephone: _____

Fax: _____

E-mail: _____

RETURN DIRECTLY TO: → **New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Chiropractic Unit, 89 Washington Avenue, Albany, NY 12234-1000.**