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.
- 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 2 BIRTH DATE 1				
(Leave this blank if you do not have a U.S. Social Security Number)  Month Day Year				
3 PRINT YOUR FULL NAME EXACTLY AS IT APPEARS ON YOUR LICENSURE APPLICATION (FORM 1)				
Last				
First				
Middle 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				
6 PRACTICE EXPERIENCE				
Name of practice:				
Practice address:				
Tradice address.				
Dates of practice: From / To / (Period must represent at least two of the immediate past five years.)				
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:      ///				

## 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:	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:		
	ECLARE AND ASSESSED FOR THE STATION  eclare and affirm that the statements above are true, com	plete and correct.	
;	Signature of licensed professional colleague:		/ Date://
			mo. day yr.
I	Print name:		mo. day yr.
1	Print name:Professional title:		mo. day yr. 
 	Print name: Professional title: License number:	State:	mo. day yr.
   	Print name: Professional title: License number:	State:	mo. day yr.
 	Print name: Professional title: License number: Address:	State:	mo. day yr.

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

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TO: