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: [ ] [ ] [ ]
   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.)

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.

January 2004

FORM 4, PAGE 1 OF 2
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.

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

1) Name of applicant: ________________________________________________________________

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: _____ / _____ / _____

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.