

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.**