



**SECTION II: VERIFICATION OF POST-DOCTORAL/GRADUATE LEVEL EDUCATION IN ANESTHESIA OR EDUCATION IN APPROVED SPECIALTY PROGRAM OR RESIDENCY**

**INSTRUCTIONS TO INSTITUTION:** Please complete this section and return this form directly to the Office of the Professions. It will **not** be accepted if it is incomplete or if it is returned by the applicant.

I hereby certify that \_\_\_\_\_  
(Dentist's Name)

Attended:  a 2 year post doctoral education program in anesthesia, or

a graduate level program in oral and maxillofacial surgery

at \_\_\_\_\_, accredited by \_\_\_\_\_  
(Dentist's School) (Accrediting body such as CDA)

from \_\_\_\_\_ through \_\_\_\_\_ and that the above named dentist successfully completed this

program on \_\_\_\_\_.  
(Date)

Please check and attach a letter of explanation with this form if this dentist did not successfully complete the training program.

**ATTESTATION**

I hereby attest that to the best of my knowledge and belief the foregoing is a true statement.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

Print or type name: \_\_\_\_\_

Title or official position: \_\_\_\_\_

Institution: \_\_\_\_\_

(INSTITUTION SEAL)

(If seal not available, attach explanation)

Address: \_\_\_\_\_

Telephone number: ( \_\_\_\_\_ ) \_\_\_\_\_

Fax: ( \_\_\_\_\_ ) \_\_\_\_\_

E-mail: \_\_\_\_\_

**Return Directly to:** New York State Education Department, Office of the Professions, Dentistry Unit, 89 Washington Avenue, Albany, NY 12234-1000.