

Section II: Verification of Licensure

Instructions to Licensing Authority: Please complete this section and return the entire form **directly** to the Office of the Professions at the address shown below. **This form will not be accepted if returned by the applicant or third party.**

1 Name of applicant: _____
(See item 3 on page 1)

License number: _____ Date issued: _____ / _____ / _____
mo. day yr.

Expiration of most recent registration: _____ / _____ / _____
mo. day yr.

- 2** a. Has the applicant named in Section I been subject to any disciplinary action? YES NO
- b. Are any charges pending against this individual? YES NO

If the answer to either of these questions is "Yes," please attach relevant information.

Certification

I certify that the information shown above is true and correct, according to the records of this office.

Signature: _____ Date: _____ / _____ / _____

Print Name: _____

Title: _____

Name of Jurisdiction: _____

Address: _____

(LICENSING
AUTHORITY
SEAL)

Telephone: _____

Fax: _____

E-mail Address: _____

Return this form Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Medicine Unit,
89 Washington Avenue, Albany, NY 12234-1000.