

**FORM 3B**

**MEDICINE**

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

**FOR ENDORSEMENT OF PRE-1972  
U.S. STATE LICENSES ONLY**

OSTEOPATHIC MEDICAL  
LICENSES

STATE MEDICAL LICENSES

**VERIFICATION OF PRE-1972 MEDICAL LICENSURE IN ANOTHER U.S. STATE OR TERRITORY**

**APPLICANT INSTRUCTIONS**

1. Complete Section I. Enter your name as it appears on your Licensure Application (Form 1). Be sure to sign and date item 7.
2. Please send this form to the appropriate U.S. state or territory where you passed a pre-1972 state or territory licensure examination. Be sure to include any fee required. The licensing authority of that jurisdiction must fully complete Section II and return the form directly to the Office of the Professions at the address at the end of this form.

**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 FULL NAME EXACTLY AS IT APPEARS ON YOUR LICENSURE APPLICATION (FORM 1):

Last

First

Middle

**4** MAILING ADDRESS: Apt./Bldg.

Street

City

State  Zip Code

Province/Country   
If not U.S.

**5** If you took a licensing examination in the United States, using a different name, enter that name below:

\_\_\_\_\_

*(Last)*

*(First)*

*(Middle)*

**6** Indicate the United States state or territory where you were licensed by a pre-1972 state or territory examination:

\_\_\_\_\_

Date license was issued \_\_\_\_ / \_\_\_\_ / \_\_\_\_ License number: \_\_\_\_\_

**7** I request and give my permission to the licensing authority listed in item 6 above to complete the information on this form and mail it to the New York State Education Department and to release any other information required by the State Education Department in connection with my application for licensure.

Applicant's signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
*mo. day yr.*

**SECTION II : CERTIFICATION OF MEDICAL LICENSURE**

**INSTRUCTION TO LICENSING AUTHORITY:** Please complete this section including names and grades on all parts of the licensing examination and return this 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 a third party.**

1. Name of Applicant: \_\_\_\_\_

2. Medical License Number: \_\_\_\_\_ Date of Licensure: \_\_\_\_\_

3. On what basis was applicant licensed in your state or territory? \_\_\_\_\_  
 \_\_\_\_\_

4. Is the licensee currently registered and in good standing?  YES  NO

5. Are charges pending against the licensee for professional misconduct, unprofessional conduct, incompetence or negligence or has the licensee ever been found guilty of such charges or surrendered a professional license?  YES  NO

If "Yes", explain \_\_\_\_\_  
 \_\_\_\_\_

6. Please specify the state or national medical examinations successfully completed by the applicant:

\_\_\_\_\_

If the applicant was licensed in your state (territory) via a state (territory)-constructed examination, please complete the following (list the exam subjects in chronological order):

Name of Examination and List of Subject Areas	Date	Grade	Minimum Passing Grade

I hereby certify that to the best of my knowledge and belief the foregoing is a true statement of the record of professional licensure of the individual named on this form.

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Print name: \_\_\_\_\_

Title: \_\_\_\_\_

Agency: \_\_\_\_\_

**(SEAL)**

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

Telephone Number \_\_\_\_\_ 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.