

**VERIFICATION OF PROFESSIONAL  
PRACTICE OF MEDICINE IN ANOTHER JURISDICTION**

**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 6.
2. Forward this form to the endorser who will attest to your professional practice of medicine and request that he/she complete Section II and Section III and return the form directly to the Office of the Professions at the address at the end of this form. Photocopy this form if you need additional affidants to verify the total number of years of professional practice required for endorsement.

**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** Name of endorsing physician: \_\_\_\_\_

If licensed in the United States, indicate state or territory: \_\_\_\_\_

**6** I request and give my permission to the individual listed in item 5 above to complete Section II of 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 : VERIFICATION OF PROFESSIONAL PRACTICE**

**ENDORSER INSTRUCTIONS**

- 1. A physician licensed and in good standing in the jurisdiction where applicant is licensed is to complete the information below and have his/her signature notarized by a Notary Public.
- 2. This completed form must be sent directly by the affiant to the Office of the Professions at the address at the bottom of this form.

**1** I know him/her to be of good moral character, and recommend him/her to the New York State Education Department as entirely worthy to be licensed to practice medicine in the State of New York.  YES  NO

**2** I have been personally acquainted with the applicant named in Section I for \_\_\_\_\_ years.

**3** I have first-hand knowledge that said applicant has \_\_\_\_\_ years and \_\_\_\_\_ months of satisfactory professional experience following medical licensure and can attest to practice by the applicant for the following:

DATE		PRACTICE LOCATION
FROM Month/Year	TO Month/Year	

**SECTION III:**

**ENDORSER AFFIRMATION**

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 endorser: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Must be signed in the presence of a notary)*

Print name as it appears on your license: \_\_\_\_\_ License number: \_\_\_\_\_

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

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

**NOTARY CERTIFICATION OF IDENTIFICATION** (Certification by Notary Public is required.)

State of \_\_\_\_\_ County of \_\_\_\_\_

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the endorser on this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Notary Public signature \_\_\_\_\_

Notary ID number \_\_\_\_\_

Expiration date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Month Day Year

**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.