

CERTIFICATION OF FIFTH (5TH) PATHWAY PROGRAM

APPLICANT INSTRUCTIONS

1. Complete Section 1. Enter your name as it appears on your Licensure Application (Form 1). Be sure to sign and date item 6.
2. Send this form to the director of your Fifth (5th) Pathway Program. This form must be sent directly to the Office of the Professions at the address at the end of this form by the director of the Fifth (5th) Pathway Program.

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: Last

First

Middle

4 MAILING ADDRESS: Apt./Bldg.

Street

City

State Zip Code

Province/Country If not U.S.

5 Fifth Pathway program director: _____

Program name: _____

Location: _____

6 I request and give my permission to the school listed in item 5 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for licensure.

Applicant's signature: _____ Date: ____ / ____ / ____

SECTION II: CERTIFICATION OF FIFTH (5TH) PATHWAY PROGRAM

This is to certify that _____ a graduate
(Physician's name)
of _____ has satisfactorily completed a Fifth (5th) Pathway
(Medical School)
Program under the direction of _____
(Medical School & address)
from _____ through _____ and that the above named physician
(Month/Day/Year) *(Month/Day/Year)*
successfully completed this program on _____.
(Date)

If this physician was the subject of adverse action by the department OR the hospital OR did not successfully complete the postgraduate training program, please attach a letter of explanation with this form Letter of explanation attached

I am the director of the Fifth (5th) Pathway Program named above. I have carefully read and completed this form and hereby attest that the statements made herein are strictly true in every respect and are supported by hospital records.

Signature of director: _____ Date: ____ / ____ / ____

Print name of director: _____

Official position: _____

(SEAL)

Telephone: _____

Fax: _____

E-mail Address: _____

**RETURN DIRECTLY
TO: →**

**New York State Education Department, Office of the Professions, Medicine Unit, Division of Professional
Licensing Services, 89 Washington Avenue, Albany, NY 12234-1000.**