THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK

OFFICE OF THE PROFESSIONS
DIVISION OF PROFESSIONAL LICENSING SERVICES

Affidavit of Agreement

(An affidavit of Agreement is not needed for an extension of a Three-Year Limited License unless you are changing your service area.)

I, _____
First Middle Last
(Print name clearly on this line)

am applying for licensure as a physician in the State of New York under the provisions of Section 6524(6) of the New York State Education Law. This law allows a three-year waiver of the licensure requirement of United States citizenship or lawful admission as an alien for permanent residence in the United States. The waiver is limited to alien physicians who practice in an area or facility designated by the New York State Education Department as medically underserved. In consideration for that waiver, I affirm and agree to the following:

1. That I understand the above requirement for a waiver and I agree to limit my practice of medicine to:

   _____
   (Print name of area or facility within New York State designated by the NYS Education Department as medically underserved)

2. That I understand that the license issued for this purpose is valid only for a maximum of 3 years (unless extended and that it may only be extended and that it may only be extended for up to another 6 years);

3. To notify the New York State Department of Health promptly in writing at the address at the end of this form of any change or potential change in employment status or location that could affect the requirement of working in this medically underserved area of New York State and to seek and obtain the New York State Department of Health's concurrence before commencing practice in another area of the State;

4. To provide the New York State Department of Health at the address at the end of this form, at least annually, with accurate and timely written information regarding my continued compliance with the requirement of working in a medically underserved area of New York State. I understand that the New York State Department of Health will confirm my continued practice in the designated area;

5. That if I practice medicine in New York in other than an approved medically underserved area or facility I will be reported to the New York State office of Professional Medical Conduct; and further affirm that I understand that such action may lead the New York State Department of Health to revoke my three-year limited license to practice medicine in New York State; and

6. That I am and will remain in compliance with U.S. Immigration and Naturalization Law.

Affirmation

I affirm that the information provided herein and submitted herewith is true and that this information will be for all purposes the equivalent of an affidavit and if it contains a false statement, shall subject me to the same penalties for perjury as if I have been duly sworn.

Signature: _____ Date: _____ / _____ / _____
mo. day yr.

Subscribed and sworn before me this _____ day of _____, 20 _____ .

Notary Public signature _____

Notary ID number _____

Notary Stamp

Expiration date _____ / _____ / _____
mo. day yr.

A. Identifying Information:

1. Name: _____
   Last *First* *Middle*

2. Mailing address: _____

   _____

   _____

3. Telephone: _____ Work: _____ E-mail: _____

4. Medical Specialty: _____

5. Social Security Number: _____

6. Type of visa currently held: _____

7. Date of birth _____ / _____ / _____
   mo. *day* *yr.*

B. List Location(s) of Proposed Practice in Medically Underserved Area *(attach additional sheets if necessary)*

1. Facility or Site: _____

   Address: _____

   City _____ State _____ Zip Code _____

   Telephone: _____ Fax: _____ E-mail: _____

   Contact person: _____

   Practice Type*: ☐ Private Practice ☐ Nursing Home ☐ Hospital ☐ HMO ☐ Diagnostic & Treatment Center

2. Facility or Site: _____

   Address: _____

   City _____ State _____ Zip Code _____

   Telephone: _____ Fax: _____ E-mail: _____

   Contact person: _____

   Practice Type*: ☐ Private Practice ☐ Nursing Home ☐ Hospital ☐ HMO ☐ Diagnostic & Treatment Center

***A copy of the employment contract/agreement MUST be attached for ALL practice types. The employment contract/agreement must specify medical specialty of practitioner and exact addresses(es) of practice facility/site.**

Note: This Section not to be completed by applicant

Approved by:

_____ _____ / _____ / _____
New York State Education Department, Division of Professional Licensing Services *mo.* *day* *yr.*

_____ _____ / _____ / _____
New York State Department of Health, Division of Health Facility Planning *mo.* *day* *yr.*

Return completed form and employment contract(s)/agreement(s) to: New York State Department of Health, Division of Health Facility Planning, Corning Tower, Room 1084, Albany, NY 12237