

Section II: Verification Of Licensure: (Please print or type)

INSTRUCTIONS TO THE LICENSING AUTHORITY: Please complete items 1-4, sign and date the certification and return this form directly to the Office of the Professions at the address below. This form will not be accepted if returned by the applicant.

1 Name of applicant: _____
(see item 6 in Section I)

2 Professional title on license/certificate: _____
License/certificate number: _____ Date of licensure/certification: ____ / ____ / ____
mo. day yr.

3 Verification of licensure
What requirements did the applicant meet to become licensed/certified in your jurisdiction?
Education: _____
Examination: Examination title: _____
Date: ____ / ____ / ____ Score: _____
Other: _____

4 A. Has the applicant identified 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 a complete explanation with any supporting documentation.

Certification

I hereby certify that to the best of my knowledge and belief the foregoing is a true statement of the record of the applicant named on this form. I further certify that, except as noted in item 4 above or in any attachments, this licensing authority has never taken any disciplinary action against this person and that in so far as the licensing authority has knowledge, there have been no charges preferred nor has any information been presented relating to any question of unprofessional or immoral conduct.

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

Print name: _____

Title: _____

Licensing authority: _____

Address: _____

City: _____ State _____

Telephone: _____ Fax: _____

E-mail Address: _____

(SEAL)

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