Medical Physicist Form 2

- ☐ **Diagnostic Radiological**
- ☐ **Medical Health**
- ☐ **Medical Nuclear**
- ☐ **Therapeutic Radiological**

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

CERTIFICATION OF PROFESSIONAL EDUCATION

APPLICANT INSTRUCTIONS

1. Complete Section I. Enter your name as it appears on your Application for Licensure and First Registration (Form 1). Be sure to sign and date item 8.
2. **For graduates of Master's and Doctoral programs** -

   Graduates of Master's and Doctoral programs from accredited United States colleges or universities must send this form to each college/university where you attended a graduate level program and request that each school complete the appropriate parts of Section II of this form and return it directly to the State Education Department with an official transcript.

   Graduates of Master's and Doctoral programs from colleges or universities located outside the United States and not accredited by a U.S. accreditation body must send this form to **every college/university attended** and request each school to complete the appropriate parts of Section II of this form and return it directly to the State Education Department with an official transcript.
3. **For students applying for a limited permit** to work as a student, send this form to the college you are attending and request that they complete the appropriate parts of Section II of this form and return it directly to the State Education Department.
4. Be sure to include any fee required by the school. A separate Form 2 should be submitted for each educational program attended that will demonstrate satisfaction of the professional education requirement.

SECTION I: APPLICANT INFORMATION

1 **Social Security Number** ☐☐☐-☐☐-☐☐☐☐

(Leave this blank if you have no U.S. Social Security Number)

2 **Birth Date** ☐☐ ☐☐ ☐☐

Month Day Year

3 **Print Your Full Name Exactly As It Appears On Your Licensure Application (Form 1)**

Last ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

First ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Middle ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

4 **Mailing Address** (You must notify the Department promptly of any address or name changes.)

Line 1 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Line 2 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Line 3 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

State ☐☐ Zip Code ☐☐☐☐☐ ☐☐☐☐

Country/ Province ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

5 Print the name under which your degree or diploma was awarded (if different from above):

_____

6 Undergraduate college or university attended: _____

Address: _____

Title of diploma or degree: _____ Date certificate, diploma or degree was awarded: _____ / _____ / _____
mo. day yr.

7 Graduate college or university attended: _____

Address: _____

Title of diploma or degree: _____ Date certificate, diploma or degree was awarded: _____ / _____ / _____
mo. day yr.

8 I request and give my permission to the schools listed in items 6 and 7 above to complete the information on this form and to send any documentation requested (e.g., an official transcript) to the New York State Education Department's Office of the Professions.

_____ _____
Applicant's signature *Date*

SECTION II : CERTIFICATION OF EDUCATION

INSTRUCTIONS TO SCHOOL: **Please complete Section II, attach an official transcript and return this form directly to the New York State Education Department at the address at the end of this form. DO NOT RETURN THIS FORM TO THE APPLICANT. This form will not be accepted if returned by the applicant.**

Name of applicant: _____
(see item 5 in Section I)

☐ Was awarded the degree of _____ on the date of _____ / _____ / _____,
mo. *day* *yr.*

in the specialty area of _____.

For limited permit as a student only:

☐ Is enrolled in a medical physicist program in the specialty area of: _____.

DESCRIPTION OF THE PROGRAM THE APPLICANT COMPLETED

(1) Program title: _____

(2) Length of program: _____

(3) Date of applicant's admission: _____ / _____ / _____ Date of Completion/Withdrawal: _____ / _____ / _____
mo. *day* *yr.* *mo.* *day* *yr.*

(4) Years of education and credential required for admission: _____

_____

_____

Note: **Please attach an official transcript or marksheet giving courses completed by year including grades and a syllabus of the course of studies completed.**

CERTIFICATION (To be completed by the Registrar)

I hereby certify that to the best of my knowledge and belief the information in Section II is a true statement of the educational record of the individual named on this form.

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

Type or print name: _____

(COLLEGE SEAL)

Title or official position: _____

Institution: _____

Location: _____

Phone: _____

Fax number: _____

E-mail address: _____

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