Medical Physicist Form 4A

- ☐ **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

VERIFICATION OF PROFESSIONAL EXPERIENCE

Applicant Instructions

1. Complete a separate Form 4A for each specialty area you are applying for.
2. Complete Section 1. Enter your name as it appears on your Licensure Application (Form 1). Be sure to sign and date the attestation below.
3. Forward this form and a copy of the instructions for Form 4A to the endorser who will attest to your professional practice of medical physics and request that he/she complete Section II 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 endorsers to verify the total number of years of professional practice required.

SECTION I: APPLICANT INFORMATION

Social Security Number:

Name: Last

First

Middle

Birth Date:

mo . day yr.

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

Telephone: Daytime Phone

Area Code Phone Number

E-Mail Address (Please print clearly)

Endorser's Name: _____

Experience described below was completed while you were employed by: _____

Address: *Street* _____

_____

City _____ *State* _____ *Zip code* _____

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

Specialty area: _____

Report of Experience - Describe in the space below your medical physicist duties during your employment with the organization named above.

Beginning _____ / _____ / _____ Ending _____ / _____ / _____ or ☐ Still employed by organization.
mo. day yr. mo. day yr.

Specialty area: _____ Clock hours in a calendar year: _____

ATTESTATION

I hereby certify that the work experience described above and the time claimed for that experience are true and accurate and give permission to the individual endorser named above to complete the information in Section II of this form and send it to the New York State Education Department.

_____ _____
Applicant's signature *Date*

VERIFICATION OF PROFESSIONAL EXPERIENCE

SECTION II: TO BE COMPLETED BY ENDORSER. (Please type or print)

INSTRUCTIONS TO ENDORSER:

1. Read carefully the applicant's Report of Experience in Section I and complete Section II. Be sure to sign and date the attestation.
2. Return this form directly to the Office of the Professions at the mailing address at the end of this form. **Do not return original to applicant. This form will not be accepted if returned by the applicant.**

Applicant's name: _____

1. I have been personally acquainted with the applicant named above for _____ years.

2. I have first-hand knowledge that the applicant has completed _____ years and _____ months of satisfactory professional experience as a medical physicist in the _____ specialty area, and that I am qualified to attest to the applicant's experience.

WITH RESPECT TO THE APPLICANT'S REPORT OF EXPERIENCE:

3. Does the description in Section I accurately reflect the work personally performed by the applicant? ☐ YES ☐ NO

4. Does the time claimed by the applicant for this experience reasonably reflect actual time? ☐ YES ☐ NO

5. Was the experience claimed by the applicant obtained as part of a successfully completed CAMPEP accredited residency? ☐ YES ☐ NO

6. Briefly identify your work relationship to the applicant at the time (i.e. direct supervisor, department head, colleague or client etc.) If none, explain.

_____

_____

_____

ATTESTATION

I declare and affirm that I have read the "Instructions for Completing Verification of Professional Experience" form and that the statements herein are true, complete and correct, and that, to the best of my knowledge, the experience reflected here is professional medical physics.

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

Print name: _____

Profession: _____ License number: _____

State: _____

Address: _____

_____

Phone: _____ Fax: _____

E-mail: _____

If you disagree with any information presented by the applicant on this form, or wish to provide any other information for consideration by the Department relative to the applicant, please submit a separate letter with this form. If you do so, please identify applicant by full name and social security number in your letter and indicate that he/she is an applicant.

A separate letter is enclosed. ☐ Yes ☐ No

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.