

Section II: Certification of Professional Education

Instructions to the Registrar: Please complete Parts A, B and C before sending both pages of this form in an official school envelope directly to the Office of the Professions at the address at the end of the form. **This form will not be accepted if submitted by the applicant or any other party.**

Name of applicant: _____
(Section I, item 5)

Part A - Creative Arts Therapy Program Registered by the New York State Education Department (NYSED) as licensure qualifying:
To be completed only by those schools whose Creative Arts Therapy program was, at the time the applicant's degree was (or will be) awarded, registered by the NYSED as licensure qualifying.

Completed the program on ____ / ____ / ____ and was awarded the degree/diploma of _____
mo. day yr. (Title of degree/diploma)

In the program area or major of _____ on the date of ____ / ____ / ____.
(Title) mo. day yr.

OR

on ____ / ____ / ____ this institution determined that the above-named student met all requirements for the degree and
mo. day yr.
the institution has agreed to award the degree/diploma of _____ on ____ / ____ / ____.
(Title of degree/diploma) mo. day yr.

Part B - All Other Programs. An official transcript or marksheet giving courses completed by year and grades and a syllabus of the course of studies completed must be attached.

1. Date of applicant's entrance, and either the applicant's date of completion of studies or withdrawal from the school:
Entrance date: ____ / ____ / ____ Completion date: ____ / ____ / ____ Withdrawal date: ____ / ____ / ____
mo. day yr. mo. day yr. mo. day yr.

2. Degree/diploma awarded: _____

3. Date degree/diploma awarded: ____ / ____ / ____
mo. day yr.
Name of accrediting body or official organization that recognizes this program: _____

Date of Accreditation: ____ / ____ / ____
mo. day yr.
Address of accrediting body or official organization that recognizes this program: _____

PART C - Certification (To be completed by ALL schools)

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 of Registrar: _____ Date: ____ / ____ / ____
mo. day yr.

Print or Type Name: _____

Title or official position: _____

Institution: _____

Address: _____

(INSTITUTION SEAL)

City: _____ State _____ Zip Code _____

Telephone: _____ Fax: _____

E-mail Address: _____

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