

PROFESSIONAL EXPERIENCE RECORD CONTINUED

No.	Exact dates (mo./day/yr.)	Type of experience including name and address of employer, supervisor, coworker or colleague.
4	____ / ____ / ____ to ____ / ____ / ____	
5	____ / ____ / ____ to ____ / ____ / ____	
6	____ / ____ / ____ to ____ / ____ / ____	
7	____ / ____ / ____ to ____ / ____ / ____	
8	____ / ____ / ____ to ____ / ____ / ____	
9	____ / ____ / ____ to ____ / ____ / ____	
10	____ / ____ / ____ to ____ / ____ / ____	

ATTESTATION

I hereby certify that the work experience time claimed and the information provided is true, accurate and complete.

Applicant signature

Date

Telephone

Fax

E-mail

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