

VERIFICATION OF EXPERIENCE

SECTION II: TO BE COMPLETED BY SUPERVISOR, EMPLOYER, COWORKER OR COLLEAGUE. (Please type or print in ink)

INSTRUCTIONS TO SUPERVISOR, EMPLOYER, COWORKER OR COLLEAGUE

1. Complete Part A and Part B.
2. Complete and sign the attestation below or, if you do not sign the attestation, please explain in a separate letter attached to this form. If you 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 the applicant by his or her full name and social security number in your letter and indicate that he/she is an applicant.

Part A – Identification of Supervisor, Employer, Co-Worker or Colleague

Name of supervisor, employer, co-worker or colleague: _____
(Please print)

Your Current Address:

Part B – Applicant’s Professional Experience

THE EMPLOYER, SUPERVISOR, COLLEAGUE, OR CO-WORKER WHO SIGNS THIS FORM ATTESTING TO THE EXPERIENCE OF THE APPLICANT MUST COMPLETE ALL OF THE FOLLOWING QUESTIONS.

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| <p>1. The applicant completes an intake interview, including a health history, whenever evaluating a patient/client for the first time.</p> <p>_____ ALWAYS
_____ SOMETIMES
_____ NEVER</p> | <p>6. The applicant has a basic knowledge of oriental massage theory.</p> <p>_____ BELOW AVERAGE
_____ AVERAGE
_____ SKILLED</p> |
| <p>2. The applicant shows skill and competence when doing an evaluation for treatment.</p> <p>_____ BELOW AVERAGE
_____ AVERAGE
_____ SKILLED</p> | <p>7. The applicant has a basic knowledge of western massage theory.</p> <p>_____ BELOW AVERAGE
_____ AVERAGE
_____ SKILLED</p> |
| <p>3. The applicant demonstrates an average or better knowledge of anatomy, physiology, and neurology when evaluating a patient’s/client’s condition.</p> <p>_____ ALWAYS
_____ SOMETIMES
_____ NEVER</p> | <p>8. The applicant is knowledgeable and applies ethical principles in practice.</p> <p>_____ ALWAYS
_____ SOMETIMES
_____ NEVER</p> |
| <p>4. The applicant demonstrates an average or better knowledge of pathology, including signs and symptoms of disorders, diseases, and specific health conditions when developing a treatment plan.</p> <p>_____ ALWAYS
_____ SOMETIMES
_____ NEVER</p> | <p>9. The applicant engages in good professional business practices, including the maintenance of confidentiality and the good recordkeeping practices.</p> <p>_____ ALWAYS
_____ SOMETIMES
_____ NEVER</p> |
| <p>5. The applicant has an average or better knowledge of myology and/or kinesiology.</p> <p>_____ BELOW AVERAGE
_____ AVERAGE
_____ SKILLED</p> | <p>10. The applicant applies appropriate massage therapy techniques for the patient’s/client’s condition.</p> <p>_____ ALWAYS
_____ SOMETIMES
_____ NEVER</p> |

AFFIDAVIT OF SUPERVISOR, EMPLOYER, CO-WORKER OR COLLEAGUE WITH ACKNOWLEDGMENT

(Notarization required unless individual cannot certify applicant's experience.)

SUPERVISOR, EMPLOYER, CO-WORKER OR COLLEAGUE

I declare and affirm that I am knowledgeable about, and qualified to attest to, the applicant's work and that, except as otherwise noted on this form, or in attached correspondence, the work experience described by the applicant and the time claimed is true and accurate. I understand that any false or misleading information on this form, or related to verification of this applicant's experience, may be cause for denial or loss of licensure in New York State and may result in criminal prosecution.

Signature of the endorser: _____

<input type="checkbox"/>	I cannot so certify. Letter of explanation attached.
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NOTARY

State of _____ County of _____

On the _____ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public signature _____

Notary ID number _____

Expiration date _____ / _____ / _____
Month Day Year

Notary Stamp

DO NOT RETURN THIS FORM TO THE APPLICANT. Mail this form 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.