Clinical Nurse Specialist Form 4
Verification of Experience

The University of the State of New York
The State Education Department
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Use this form ONLY if you are following alternative requirements for a certificate prior to September 15, 2017

Applicant Instructions

1. Complete Section I. In item 4, enter your name exactly as it appears on your Application for a Clinical Nurse Specialist Certificate (Form 1). Be sure to sign and date item 7.
2. Send the entire form to the clinical supervisor who has been responsible for supervising the work for which you are seeking credit and ask her/him to complete Section II and send **both pages** of the form directly to the Office of the Professions at the address at the end of this form. **This form will not be accepted if submitted by the applicant or any other party**.
3. A separate form 4 must be provided by each supervisor with whom you worked while acquiring the required experience.

Section I - Applicant Information

1. Social Security Number ☐☐☐☐☐☐☐☐☐ 2. Birth Date Month ☐☐ Day ☐☐ Year ☐☐☐☐

(Leave this blank if you do not have a U.S. Social Security Number)

3. New York State Registered Professional Nurse License Number ☐☐☐☐☐☐

4. Print Your Name Exactly As It Appears On Your Application for a Clinical Nurse Specialist Certificate (Form 1)

Last ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

First ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Middle ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

5. Clinical nurse specialist specialty area for which you are applying _____

6. Name of clinical supervisor _____

7. I authorize the clinical supervisor named above to provide any information requested, including the information requested on this form, to the New York State Education Department.

_____ _____
Applicant's Signature Date

Section II - Verification of Experience - To be completed by the Clinical Supervisor

The individual named above is seeking certification as a clinical nurse specialist in the specialty area named in (5) above*.

***Note: To qualify for certification as a clinical nurse specialist, the applicant must have completed after January 1, 2011 at least three thousand hours of clinical practice in a clinical nurse specialty area in a general hospital pursuant to Article 28 of the Public Health Law in New York State.**

Please complete Section II, sign and date the certification and return **both pages** of this form directly to the Office of the Professions at the address at the end of the form.

Name of General Hospital _____

Address _____

In what capacity was the applicant employed in? _____

☐ Full time ☐ Part time Inclusive dates (note interruptions) From ___ ___ ___ To ___ ___ ___
mo. day yr. mo. day yr.

Number of hours of clinical practice in the clinical nurse specialist related field _____

Type of clinical nurse specialist experience (check one) ☐ Adult Health ☐ Oncology ☐ Pediatrics ☐ Psychiatry

Section II - Verification of Experience (Continued) - To be completed by the Clinical Supervisor

Certification

I certify that the information provided in Section II of this form is complete and accurate to the best of my knowledge and that I have personally supervised the person named in this form in the performance of the competencies listed above.

Clinical Supervisor Signature _____ Date _____

Print Name _____

Title _____

New York State License Number ☐☐☐☐☐☐

Profession _____

Telephone _____ Fax _____

Email _____

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

Reset Form