

# Nurse Practitioner Form 4

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

Department Use Only

Approved

Date

## Verification of Experience

(Use this form ONLY if you are following pre-1989 alternative requirements for a certificate.)

### Applicant Instructions

1. Complete Section I. In item 4, enter your name exactly as it appears on your Application for a Certificate (Form 1). Be sure to sign and date item 7.
2. Send the entire form to the physician 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 physician with whom you worked while acquiring the required experience.

### Section I: Applicant Information

<b>1</b>	<b>Social Security Number</b>	<input type="text"/>	<b>2</b>	<b>Birth Date</b>	Month	<input type="text"/>	<input type="text"/>	Day	<input type="text"/>	<input type="text"/>	Year	<input type="text"/>	<input type="text"/>										
<i>(Leave this blank if you do not have a U.S. Social Security Number)</i>																							
<b>3</b>	<b>New York State Registered Professional Nurse License Number</b>	<input type="text"/>										<b>4</b>	<b>Print Name as It Appears on Your Application for a Certificate (Form 1)</b>										
													Last	<input type="text"/>									
													First	<input type="text"/>									
													Middle	<input type="text"/>									

**5** Nurse practitioner specialty area for which you are applying: \_\_\_\_\_

**6** Name of supervising physician: \_\_\_\_\_

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

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

### Section II: Verification of Experience - To be completed by the Supervising Physician

The individual named above is seeking certification as a nurse practitioner in the specialty area named in (5) above. **This application is partially based upon two years of experience prior to April 1, 1989, at least one year of which shall be subsequent to April 1, 1986, in the provision of primary health care services in a health care facility licensed pursuant to Article 28 of the Public Health Law or in a school health demonstration project.** The purpose of this objective performance evaluation is to determine the competency of the nurse practitioner to provide primary care in the specified specialty area. It is a summary evaluation based upon your firsthand observation, anecdotal notes, and other documentation of the applicant's consistent performance.

The rating is either "satisfactory," "unsatisfactory," or "not applicable." A checkmark will indicate the rating. There is space at the end of the form to provide any additional comments you may have regarding the performance of this individual (attach additional sheets, if required).

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 Institution: \_\_\_\_\_

Address: \_\_\_\_\_

Article 28 facility?  Yes  No If yes, since: \_\_\_\_\_  
Year

In what capacity was the applicant employed? \_\_\_\_\_

Full time  Part time Inclusive dates (note interruptions): From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr. mo. day yr.

Specialty or clinical area of experience: \_\_\_\_\_

If available, please attach job description.

**Section II: Verification of Experience (Continued) - To be completed by the Supervising Physician**

**Summary Performance Evaluation**

		Satis- factory	Unsatis- factory	Does not apply
<b>A. Health Assessment</b>				
1.	Demonstrates skillful interviewing of clients.			
2.	Elicits an age-appropriate comprehensive health history.			
3.	Elicits and records information specific to the client's complaints (e.g., onset, timing, duration, location, associated symptoms, alleviating factors, quantity/intensity, etc.).			
4.	Performs a complete physical examination.			
5.	Demonstrates use of appropriate techniques of inspection, palpation, percussion, and auscultation throughout the examination.			
6.	Prepares client charts for review according to the facilities schedule.			
7.	Differentiates normal from abnormal findings.			
8.	Uses appropriate equipment accurately & efficiently when performing a physical examination.			
9.	Adapts the history and physical to meet the needs of individual clients.			
10.	Selects appropriate diagnostic tests to gather information necessary to evaluate the health status of a client.			
11.	Records information in a well-organized, concise manner.			
12.	Analyzes all data in order to formulate an assessment of the client's status and establish a plan of care.			
13.	Identifies specific health promotion/maintenance needs of clients and families.			
14.	Describes etiology, developmental considerations, pathogenesis and clinical manifestations of specific disease processes.			
15.	Correlates pathophysiology with client's signs & systems.			
16.	Correlates pathophysiology with laboratory data.			
17.	Demonstrates knowledge of pathophysiology of acute and chronic diseases or conditions commonly encountered in the practice setting.			
<b>B. Technical Skills</b>				
1.	Performs and interprets selected laboratory tests.			
2.	Performs technical skills specific to practice setting.			
3.	Performs therapeutic maneuvers skillfully.			
<b>C. Management of Acute and Chronic Illnesses</b>				
1.	Assesses and manages most common acute illnesses according to areas of preparation, age of client, legal parameters and current standards of practice.			
2.	Assesses and manages stable chronic illnesses according to areas of preparation, age of client, legal parameters and current standards of practice.			
3.	Identifies and manages emergency or crisis situations.			
4.	Collaborates with health team members and makes appropriate referrals.			
5.	Demonstrates diagnostic reasoning ability in formulating assessments.			

**Please attach a comment on the applicant's overall competence to provide primary care services in the designated specialty area.**

**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.

Physician signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mo. day yr.

Print name: \_\_\_\_\_

Title: \_\_\_\_\_

New York State medical license number:

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

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