



**SECTION II : CERTIFICATION OF EDUCATION**

**INSTRUCTIONS TO THE REGISTRAR:**

1. Use this form to verify professional education from a New York State registered licensure-qualifying or AOTA accredited program.
2. Complete Parts A and B and return this form directly to the Office of the Professions at the address at the end of this form in an official school envelope. Do not return this form to the applicant.

**PART A – PROGRAM COMPLETED:**

The applicant named below completed an occupational therapy or occupational therapy assistant program that was, at the time the degree requirements were met, either:

- Registered as licensure qualifying by the New York State Education Department,  
**AND/OR**
- Accredited by the American Occupational Therapy Association.

It is certified that \_\_\_\_\_ :  
*(Name of applicant – See Section I, item 5)*

- met all requirements for the degree/diploma of \_\_\_\_\_ on \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
*(Title of degree/diploma) mo. day yr.*
- was awarded the degree/diploma of \_\_\_\_\_ on \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
*(Title of degree/diploma) mo. day yr.*

**PART B - CERTIFICATION:** This form will not be accepted if the date below precedes the date when the degree was awarded.

**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 or designee \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
*mo. day yr.*

Type or print name \_\_\_\_\_

Title or official position \_\_\_\_\_

Institution \_\_\_\_\_

Address \_\_\_\_\_

**(SEAL OF INSTITUTION)**

Telephone number \_\_\_\_\_ Fax \_\_\_\_\_

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

**RETURN DIRECTLY TO:** →

**New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Occupational Therapy Unit, 89 Washington Avenue, Albany, NY 12234-1000.**