Pathologists' Assistant Form 4
Verification of Practice

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 applying for licensure under the Grandparenting Licensure Pathway (Available until November 28, 2019)
Only Supervised Experience gained between November 28, 2012 and November 28, 2017
may be used to meet the Grandparenting Requirements

Applicant Instructions

Complete Section I. In item 3, enter your name exactly as it appears on your Application for Licensure (Form 1). Be sure to sign and date item 7. Send the entire form to the physician* who supervised your performance of the duties of a pathologists' assistant and ask that they complete Section II and send all pages of the form directly to the Office of the Professions at the address at the end of the form. **This form will not be accepted if submitted by the applicant**.

A separate Form 4 must be submitted for each instance of practice used towards meeting the Grandparenting requirements.

***Note: The supervising physician must be a licensed physician practicing anatomic pathology.**

Section I - Applicant Information

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

2. Birth Date Month Day Year

3. Print Your Name Exactly As It Appears On Your Application for Licensure (Form 1)

Last
First
Middle

4. Mailing Address (You must notify the Department promptly of any address or name changes)

Line 1
Line 2
Line 3
City
State ZIP Code
Country/ Province

5. Telephone/Email Address

Daytime Phone
Area Code Phone

Email Address (please print clearly)

6. Supervising Physician you are sending this form to

Hospital/Organization where the supervision took place

Hospital/Organization Address

Dates of supervision Date beginning ___ ___ ___ (mo. day yr.) Date ending ___ ___ ___ (mo. day yr.)

7. I request and give my permission to the supervising physician named in item 6 above to complete Section II of this form and mail it to the New York State Education Department and to release any other information required by the State Education Department in connection with my application for licensure.

Applicant's Signature Date

Section II - Verification of Practice

Instructions to the Supervising Physician*: Complete this section and return all pages of this form **directly** to the Office of the Professions at the address below. Do not return this form to the applicant. **This form will not be accepted if returned by the applicant.** Please be sure the return address is that of the supervisor or the agency.

***Note: To be acceptable as a supervising physician for licensure requirement purposes, you must be a licensed physician practicing anatomic pathology.**

Name of the applicant _____
(see Section I, item 3)

Supervising Physician's Name _____

Are you a licensed physician who practices anatomic pathology? ☐ Yes ☐ No

If "yes", in what Jurisdiction? _____ License number: _____

Hospital/Organization where supervision took place _____

Hospital/Organization Address _____

Hospital/Organization Telephone _____ Fax _____ Email _____

Dates of supervision Date beginning ___ ___ ___ (mo. day yr.) Date ending ___ ___ ___ (mo. day yr.)

Did the applicant practice as a pathologists' assistant as defined in Section 8850 Subdivision (4) of Article 168 of New York's Education Law during the period of supervision indicated above? ☐ Yes ☐ No

In your judgment, is the applicant competent to practice as a pathologists' assistant as defined in Section 8850 Subdivision (4) or Article 168 of New York's Education Law? ☐ Yes ☐ No

Attestation

I hereby certify that I am the supervising physician for the applicant named on this form, that I am knowledgeable about, and qualified to attest to, the applicant's work experience and that the applicant has the requisite experience, within the scope of practice for Pathologists' Assistant, as defined in Education Law §8850(4). I understand that any false or misleading information made in, or in connection with, my certification of this form may result in disciplinary action against my license and/or loss of my licensure and may result in criminal prosecution.

_____ _____
Supervising Physician's Signature Date

Print Name _____

Address _____

Telephone _____ Fax _____

Email _____

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

Reset Form