Perfusionist 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

Verification of Practice

Use this form only if you are applying for licensure under the Grandparenting provision (Available until October 20, 2018)

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 hospital/organization where you were employed and ask that they complete Section II and send both pages of the form directly to the Office of 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.

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 Name As It Appears On Your Application for Licensure (Form 1)**

Last
First
Middle

5 **Telephone/E-Mail Address**

Daytime phone
Area Code Phone

E-mail Address (please print clearly)

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

6 Name of Hospital/Organization where I was employed:

_____

Address: _____

Duration of employment: Date beginning: _____ / _____ / _____ Date ending: _____ / _____ / _____
mo. day yr. mo. day yr.

7 I request and give my permission to the hospital/organization 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.

_____ _____
Signature of applicant Date

Section II: Verification of Practice

Instructions to the Authorized Representative: Complete this section and return both pages of this form directly to the Office of the Professions at the address at the end of the form. 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.**

Name of Applicant: _____
(Section I, item 3)

Hospital/Organization Information

Hospital/Organization name: _____

Address: _____

Telephone: _____ Fax number: _____ E-mail: _____

Applicant's Employment

Was the applicant employed by your organization as a perfusionist? ☐ Yes ☐ No

Duration of employment: Beginning: _____ / _____ / _____ Ending: _____ / _____ / _____
mo. day yr. mo. day yr.

Did the applicant practice as a perfusionist as defined in Section 6630 Subdivision (3) of Article 134 of New York's Education Law during the period indicated above? ☐ Yes ☐ No

Is the setting in which the applicant worked an inpatient unit that provides cardiac surgery services in a hospital approved by the Department of Health or a substantially equivalent accrediting body acceptable to the Committee for Perfusion and the Department? ☐ Yes ☐ No

Attestation

I declare and affirm under penalty of perjury that I am authorized by the employing organization to complete the above information and that the statements made are true, complete and correct. Any false or misleading information in, or in connection with, this certification may be cause for denial of license and may result in criminal prosecution.

_____ Date: _____ / _____ / _____
Signature of Authorized Representative mo. day yr.

_____
Print or type name

_____
Title

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