



**Section II Verification of Employing Hospital**

1. Complete this section and be sure to sign and date the attestation. The hospital employer is certifying that the permittee named will practice under the direction and supervision of a licensed physician.
2. This form must be submitted directly by the employing hospital 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.
3. The permit cannot be issued until the applicant's application is approved.

Applicant's name: \_\_\_\_\_  
Section I, item 3

**Employing Hospital**

Name of employing hospital: \_\_\_\_\_

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

Contact person: \_\_\_\_\_

\_\_\_\_\_  
Street City State Zip code

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

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

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

Provide a description of the qualifications established by the hospital to perform extracorporeal or intracorporeal services under the direction and supervision of a licensed physician:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Attestation**

I declare and affirm, under penalty of perjury, (1) that I am authorized by the employing hospital to submit this form, (2) that the applicant is employed on a salaried basis by the above identified hospital, (3) that the applicant meets the qualifications established by such hospital to perform extracorporeal or intracorporeal services under the direction and supervision of a licensed physician, and (4) that the statements made in the foregoing certification are true, complete and correct. Any false or misleading information in or in connection with this certification may be cause for denial of permit and may result in criminal prosecution.

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Print 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.**