



**Section II: Certification of Experience**

**Instructions to Colleague:** Complete Section II, Items A and B, sign and date the attestation and send both pages of this form directly to the address at the end of this form. **This form will not be accepted if returned by the applicant.**

**A. Colleague's Qualifications:**

I am a licensed \_\_\_\_\_ in \_\_\_\_\_  
Professional Title Jurisdiction

\_\_\_\_\_  
License number (Attach a copy of your license if other than New York) Date licensed

**B. Experience Information:** I am attesting that \_\_\_\_\_  
Applicant Name

practiced physical therapy (**defined in Section I, item 6**) as follows.

\_\_\_\_\_  
Address of setting where experience took place City State Zip Code

Dates of licensed Experience: From \_\_\_\_ / \_\_\_\_ / \_\_\_\_ To \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Present  
mo. day yr. mo. day yr.

**Affirmation** (To be completed by colleague verifying experience)

I declare and affirm under penalty of perjury that the statements made in the foregoing application, including any attached statements, are true, complete and correct and that the experience I am attesting to meets the definition of licensed practice in physical therapy.

Check here if you are attaching additional information.

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mo. day yr.

Print Name: \_\_\_\_\_

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

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

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

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