

PART C - CERTIFICATION

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.

Print school official's name: _____

Title: _____

School: _____

Address: _____

Telephone: _____

Fax: _____

(SEAL OF INSTITUTION)

E-mail: _____

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