FORM 2CC

MEDICINE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

Applicants who completed one or more clinical clerkships in a country other than where medical school is located must complete this form.

CERTIFICATION OF APPROVED CLINICAL CLERKSHIP

APPLICANT INSTRUCTIONS

1. Complete Section I. Enter your name as it appears on your Licensure Application (Form 1). Be sure to sign and date item 7.
2. If you completed one or more clinical clerkships in a country other than where your medical school is located, send an individual form to each of the directors of medical education of the hospitals in which you completed each clerkship. The director **must** complete Section II and return the form directly to the Office of the Professions at the address at the end of this form.
3. One form must be submitted to verify each clerkship. If you have completed more than one clerkship, please photocopy the form.
4. If the hospital in which you did your clerkship does not have a director of medical education, the forms may be completed by the department chair.
5. **DO NOT USE this form for clerkships completed for CETEC, CIFAS, and UTESA.** You should contact the Bureau of Comparative Education at (518) 474-3817 ext. 300 and request a form to complete for these clerkships.

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 FULL NAME EXACTLY AS IT APPEARS ON YOUR LICENSURE APPLICATION (FORM 1)

Last _____

First _____

Middle _____

4 MAILING ADDRESS

Apt./Bldg. _____

Street _____

City _____

State ____ Zip Code _____ - ____

Province/Country If not U.S. _____

5 Print name under which clinical training was completed: _____

6 Hospital in which clinical training was completed: _____

Address: _____

7 I request and give my permission to the hospital listed in item 6 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for licensure.

Applicant's signature: _____ Date: _____ / _____ / _____

SECTION II : HOSPITAL CERTIFICATION OF CLINICAL TRAINING (PLEASE PRINT OR TYPE)

This is to certify that _____
(Student's name)

a student of _____ participated in a clerkship
(*Medical School)*

offered by _____
(Name and location of hospital)

from _____ through _____ in the clinical area of _____
Month/Day/Year *Month/Day/Year*

and that the above named student successfully completed this clerkship on _____ . The hospital
Month/Day/Year

☐ does or ☐ does not have an approved residency program in this clinical area. If this student did not successfully complete the clerkship, please attach a letter of explanation with this form. The clerkship conforms to provisions of statute and regulation in

_____ at time clerkship was completed.
(State)

I am the director of medical education or department chair of the clinical area of the clerkship indicated. I have carefully read and completed this form and hereby attest that the statements made herein are true in every respect and supported by hospital records.

Signature of Director/Chair: _____ Date: _____ / _____ / _____

Print or type name of Director/Chair: _____

Title or official position: _____ **(SEAL)**

Institution: _____

Address: _____

_____

Telephone: _____ Fax: _____

E-mail Address: _____

RETURN DIRECTLY TO: → **New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Medicine Unit, 89 Washington Avenue, Albany, NY 12234-1000.**