

Creative Arts Therapist Form 4F Certification of Licensed Experience

This form is for applicants seeking licensure in New York State by endorsement of a license to practice Creative Arts Therapy issued from another jurisdiction. You must have at least 5 years of licensed experience in Creative Arts Therapy in the 10 year period prior to applying for licensure.

Applicant Instructions

Assigned Number (from Form 4E): _____

1. Complete Section I. Be sure to sign and date item 9.
2. Send the entire form to your licensed colleague who will certify your licensed experience to complete Section II and forward all pages of this form directly to the Office of the Professions at the address at the end of this form. **This form will not be accepted if submitted by the applicant.**

Section I: Applicant Information

1. Last 4 Digits of 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 Last
 First
 Middle
5. Telephone/Email Address
Daytime Phone
 Home or Business

Licensee business address, phone and email address are public information. Failure to indicate business or home on this form for each item will deem it public information.

4. Mailing Address Home or Business
(You must notify the Department within 30 days of any address or name changes)
Line 1 _____
Line 2 _____
Line 3 _____
City _____
State ZIP Code _____
Country/
Province _____
- Area Code Phone _____
Email Address (please print clearly)
 Home or Business _____
6. New York State DMV ID Number
(Driver or Non-Driver ID)

(Leave this blank if you do not have a New York State DMV ID Number)

7. Name as it appears on degree or other credentials (if different from above) _____

8. Name of licensed colleague _____ Assigned Number (from Form 4E): _____

I practiced Creative Arts Therapy as defined below:

"Creative Arts Therapy is the assessment, evaluation, and the therapeutic intervention and treatment, which may be either primary, parallel or adjunctive, of mental, emotional, developmental and behavioral disorders through the use of the arts as approved by the Department; and the use of assessment instruments and mental health counseling and psychotherapy to identify, evaluate and treat dysfunctions and disorders for purposes of providing appropriate Creative Arts Therapy services."

Jurisdiction where I practiced Creative Arts Therapy _____

Date of licensure mo. day yr. License Number _____

9. I request and give my permission to the individual listed in item 8 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. I also declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of licensure and may result in criminal prosecution.

Applicant Signature _____ Date _____

Section II: Certification of Licensed Experience

Instructions to the Licensed Colleague: Complete Section II, sign and date the attestation and send the entire form along with any additional information directly to the Office of the Professions at the address at the end of this form. **This form will not be accepted if submitted by the applicant.**

Name of the applicant _____
(see Section I, item 3)

I am a licensed _____ in _____
Professional title Jurisdiction

License number (attach a copy of your license if other than New York State) _____ Date licensed _____
mo. day yr.

I am attesting that the above named applicant practiced creative arts therapy (defined below):

“Creative Arts Therapy is the assessment, evaluation, and the therapeutic intervention and treatment, which may be either primary, parallel or adjunctive, of mental, emotional, developmental and behavioral disorders through the use of the arts as approved by the Department; and the use of assessment instruments and mental health counseling and psychotherapy to identify, evaluate and treat dysfunctions and disorders for purposes of providing appropriate Creative Arts Therapy services.”

Address of setting where applicant practice creative arts therapy

Dates of licensed experience From _____ To _____
mo. day yr. mo. day yr.

Attestation

I declare and affirm 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 Creative Arts Therapy. I understand that any false or misleading information on this form, or related to verification of this applicant's experience, may be cause for charges of misconduct and/or criminal prosecution.

Colleague Signature _____

Date _____

Print Name _____

Address _____

Telephone _____ Fax _____

Email _____

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