The University of the State of New York
The State Education Department
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Massage Therapist Form 4B
Verification of Experience

For Endorsement Applicants Only
Use this form only if you are licensed in another state, province or country and are seeking licensure by endorsement.

Applicant Instructions

Complete Section I. Be sure to sign and date item 9. Make a copy of this form for your records. Forward all pages of this form to the supervisor, employer, co-worker or colleague who will attest to your work experience and ask that they complete Section II and submit this form to the Office of the Professions at the address at the end of the form. A separate form 4B will need to be submitted for each supervisor, employer, co-worker or colleague you listed on Form 4. This form will not be accepted if submitted by the applicant.

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 Name
Last
First
Middle

5. Telephone/Email Address
Daytime Phone
☐ Home or ☐ Business
Area Code Phone

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

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. Experience was obtained while employed or self-employed by
Self/Organization Name
Address
Street
City State ZIP Code
Beginning ___ (mo.) _____ (yr.) and ending ___ (mo.) _____ (yr.) Average hours per week* _____ Number of weeks per year _____
*The experience must include, at minimum, an average of 12 hours of massage therapy per week.

8. I have practiced (check one)
☐ Oriental massage therapy
☐ Western massage therapy
☐ Oriental and western massage therapy

9. I declare and affirm that the statements made in the foregoing application, including accompanying statements 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 of licensure and may lead to a filing of charges of professional misconduct.

Applicant's Signature Date

Section II - Verification of Experience - To be completed by supervisor, employer, co-worker or colleague. ***(please type or print in ink)***

Instructions: Complete Parts A and B. Be sure to complete and sign the affidavit before submitting all pages of this form and any attached documentation to the Office of the Professions at the address at the end of the form. If you do not sign the affidavit, please explain in a separate letter attached to this form. If you wish to provide any other information for consideration by the Department relative to the applicant, please submit a separate letter with this form. If you do so, please identify the applicant by his or her full name and last 4 digits of their social security number in your letter and indicate that he or she is an applicant. **This form will not be accepted if submitted by the applicant.**

Name of the applicant _____

(see Section I, item 3)

Part A - Identification of Supervisor, Employer, Co-Worker or Colleague

Name _____

Current Address

Street _____

City _____ State _____ ZIP Code _____

Telephone _____ Fax _____ Email _____

Basis on which you know the applicant ☐ Supervisor ☐ Employer ☐ Co-worker ☐ Colleague

Part B - Applicant's Professional Experience

You must complete all of the following questions.

1. The applicant completes an intake interview, including a health history, whenever evaluating a patient/client for the first time.
   ☐ Always ☐ Sometimes ☐ Never
2. The applicant shows skill and competence when doing an evaluation for treatment.
   ☐ Below Average ☐ Average ☐ Skilled
3. The applicant demonstrates an average or better knowledge of anatomy, physiology, and neurology when evaluating a patient's condition.
   ☐ Always ☐ Sometimes ☐ Never
4. The applicant demonstrates an average or better knowledge of pathology, including signs and symptoms of disorders, diseases, and specific health conditions when developing a treatment plan.
   ☐ Always ☐ Sometimes ☐ Never
5. The applicant has an average or better knowledge of myology and/or kinesiology.
   ☐ Below Average ☐ Average ☐ Skilled
6. The applicant has a basic knowledge of oriental massage therapy.
   ☐ Below Average ☐ Average ☐ Skilled
7. The applicant has a basic knowledge of western massage therapy.
   ☐ Below Average ☐ Average ☐ Skilled
8. The applicant is knowledgeable and applies ethical principles in practice.
   ☐ Always ☐ Sometimes ☐ Never
9. The applicant engages in good professional business practices, including the maintenance of confidentiality and good recordkeeping practices.
   ☐ Always ☐ Sometimes ☐ Never
10. The applicant applies appropriate massage therapy techniques for the patient's/client's condition.
    ☐ Always ☐ Sometimes ☐ Never

Section II - Verification of Experience - To be completed by supervisor, employer, co-worker or colleague. (Continued)

Affidavit

Supervisor, Employer, Co-Worker or Colleague

I declare and affirm that I am knowledgeable about, and qualified to attest to, the applicant's work and that, except as otherwise noted on this form, or in attached correspondence, the work experience described by the applicant and the time claimed is true and accurate. I understand that any false or misleading information on this form, or related to verification of this applicant's experience, may be cause for denial or loss of licensure in New York State and may result in criminal prosecution.

Endorser's Signature _____ Date _____

☐ I cannot so certify. I am attaching a letter of explanation

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Massage Therapy Unit, 89 Washington Avenue, Albany, NY 12234-1000. **OR, Submit this form to the Department by E-mail at DPLSExperience@nysed.gov.**