

Respiratory Form 3

Verification of Other Professional Licensure/Certification

Complete this form if you hold, or have ever held, a license or certificate to practice any profession* in any jurisdiction.
*Profession is defined as professional titles licensed under New York State Education Law.

Applicant Instructions

1. Complete Section I. Be sure to sign and date item 9.
2. Send the entire form to the appropriate licensing/certifying authority for completion of Section II. Be sure to include any fee required by that licensing/certifying authority. We must receive a Form 3 for all professional licenses/certificates you ever held except those issued by New York State Education Department. **This form will not be accepted if submitted by the applicant.**

Check what you are applying for (check one):

- Respiratory Therapist
 Respiratory Therapist Technician

Section I: Applicant Information

1. Social Security Number _____ 2. Birth Date Month Day Year
(Leave this blank if you do not have a U.S. Social Security Number)

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 promptly of any address or name changes)

- Area Code Phone
Email Address (please print clearly)
 Home or Business

Line 1

Line 2

Line 3

City

State

ZIP Code

Country/
Province

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 of licensing/certifying authority to which this form is being sent _____

8. Print your name as it appears on the license/certificate issued by the licensing/certifying authority listed above.

Name _____

Professional title on license/certificate issued _____

9. I request and give my permission to the licensing authority to complete the information on this form and send any documentation requested, including that requested on this form, to the New York State Education Department at the address at the end of this form. 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.

Signature _____ Date _____

Section II: Verification of Licensure/Certification (Please Print)

Instructions to the Licensing/Certifying Authority: If the applicant was licensed/certified in your jurisdiction, complete items 1-4, sign and date the certification and return both pages of this form in an official envelope **directly** to the Office of the Professions at the address at the end of this form. **This form will not be accepted if returned by the applicant.** Attach additional sheets if necessary.

1. Name of the applicant _____
(see Section I, item 8)

2. Professional title on license/certificate _____
License/certificate number _____ Date of licensure/certification _____
mo. day yr.

3. Verification of licensure/certification
What requirements did the applicant meet to become licensed/certified in your jurisdiction?
Education: Degree/Diploma/Certificate _____
Examination: Examination Title _____ Date _____ Score _____
mo. day yr.
Experience: None
 _____ Hour(s) Describe _____
 Endorsement of license/certificate from or reciprocity with _____
(name of jurisdiction)

4. A. Has the applicant been subject to any disciplinary action? Yes No
B. Are any charges pending against this license/certificate? Yes No
If the answer to either A or B is "yes", please attach a complete explanation with any supporting documentation.

Certification

I certify that to the best of my knowledge and belief the foregoing is a true statement of the record of the applicant named on this form. I further certify that, except as noted above or in any attachments, this licensing/certifying authority has never taken any disciplinary action against this person and that in so far as the licensing/certifying authority has knowledge, there have been no charges preferred nor has any information been presented relating to any question of unprofessional or immoral conduct.

Signature _____ Date _____
Print Name _____
Title _____
Name of Licensing/Certifying Authority _____
Address _____ Seal
Telephone _____ Fax _____
Email _____

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.