## **Restricted Dental** Faculty Form 4

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

## **Affidavit of Professional Practice**

## **Applicant Instructions**

- Complete Section I. In item 3, enter your name exactly as it appears on your Application for Licensure (Form 1). Be sure to sign and date item 6.
- Send the entire form to a dentist licensed and in good standing in the jurisdiction in which you practiced during the time period listed in

|           | item 5 and ask they complete Section II to certify your professional practice as a dentist and return both pages of the form directly to the Office of the Professions at the address at the end of the form. This form will not be accepted if submitted by the applicant. |        |          |       |        |           |       |               |           |             |           |      |      |      |      |      |          |              |          |        |       |          |          |           |     |    |     |     |   |   |    |     |   |    |     |    |    |   |
|-----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|----------|-------|--------|-----------|-------|---------------|-----------|-------------|-----------|------|------|------|------|------|----------|--------------|----------|--------|-------|----------|----------|-----------|-----|----|-----|-----|---|---|----|-----|---|----|-----|----|----|---|
|           | You may need to have more than one affidavit submitted for comprehensive certification of the required two years of professional practice within the last five years. Please photocopy the form as needed.                                                                  |        |          |       |        |           |       |               |           |             |           |      |      |      |      |      |          |              |          |        |       |          |          |           |     |    |     |     |   |   |    |     |   |    |     |    |    |   |
| Sec       | tion I: A                                                                                                                                                                                                                                                                   | ppli   | can      | nt In | fori   | mat       | ion   |               |           |             |           |      |      |      |      |      |          |              |          |        |       |          |          |           |     |    |     |     |   |   |    |     |   |    |     |    |    |   |
| 1         | Social Security Number (Leave this blank if you do not have                                                                                                                                                                                                                 |        |          |       |        |           | /e a  |               |           |             |           |      |      |      |      |      |          |              | Day      |        |       |          | Υe       | ear       |     |    |     |     |   |   |    |     |   |    |     |    |    |   |
| 3         | Print Na                                                                                                                                                                                                                                                                    | me     | as       | lt A  | ppe    | ars       | on    | Υοι           | ır A      | pp          | icat      | ion  | for  | Lic  | en   | sur  | e (F     | orr          | n 1)     |        |       |          |          |           |     |    |     |     |   |   |    |     |   |    |     |    |    |   |
|           | Last                                                                                                                                                                                                                                                                        |        |          |       |        |           |       |               |           | Γ           | Τ         | Τ    | T    | Τ    | Т    |      |          |              |          |        |       |          |          |           |     |    |     |     |   |   |    |     |   |    |     |    |    |   |
|           | First                                                                                                                                                                                                                                                                       |        |          |       |        |           |       |               |           |             |           |      |      |      |      |      |          |              |          |        |       |          |          |           |     |    |     |     |   |   |    |     |   |    |     |    |    |   |
|           | Middle                                                                                                                                                                                                                                                                      |        |          |       |        |           |       |               |           |             |           |      |      |      |      |      |          |              |          |        |       |          |          |           |     |    |     |     |   |   |    |     |   |    |     |    |    |   |
| 4         | Mailing                                                                                                                                                                                                                                                                     | ۸۵     | droc     | se /\ | Vau    | muo       | t not | if., 4        | ·ha [     | <b>J</b> on | ortm      | ont  | nror | nnth | ı of | on   | , ad     | droo         | o or     | nome   | o oba | ona      | ۱۵۵ /    |           |     |    |     |     |   |   |    |     |   |    |     |    |    |   |
| •         | Mailing Address (You must notify the Department promptly of any address or name changes.)                                                                                                                                                                                   |        |          |       |        |           |       |               |           |             |           |      |      |      |      |      |          |              |          |        |       |          |          |           |     |    |     |     |   |   |    |     |   |    |     |    |    |   |
|           | Line 1<br>Line 2                                                                                                                                                                                                                                                            | -      | <u> </u> | +     | +      | <u> </u>  | +     | $\frac{1}{1}$ | +         | +           | +         | +    | +    | _    |      |      | <u> </u> | <u> </u>     | <u> </u> |        |       | <u></u>  | <u> </u> | $\exists$ |     |    |     |     |   |   |    |     |   |    |     |    |    |   |
|           | Line 3                                                                                                                                                                                                                                                                      |        | 1        | +     | $^{+}$ | +         | +     | $\dagger$     | +         | $\dagger$   | $^+$      | +    | +    | _    |      |      |          | +            | 1        | 1      |       | _        | +        | $\exists$ |     |    |     |     |   |   |    |     |   |    |     |    |    |   |
|           | City                                                                                                                                                                                                                                                                        |        |          | +     | $^{+}$ | $\dagger$ | +     | T             | $\dagger$ | Ť           | $\dagger$ | †    |      | _    |      |      |          | <del> </del> |          |        |       | <u> </u> | <u> </u> | _         |     |    |     |     |   |   |    |     |   |    |     |    |    |   |
| State Zip |                                                                                                                                                                                                                                                                             |        |          |       |        |           |       |               | p C       | ode         | , [       | T    |      |      |      |      |          | T            |          |        |       |          |          |           |     |    |     |     |   |   |    |     |   |    |     |    |    |   |
|           | Country/<br>Province                                                                                                                                                                                                                                                        |        |          |       |        |           |       |               |           |             |           |      |      |      |      |      |          |              |          |        |       |          |          |           |     |    |     |     |   |   |    |     |   |    |     |    |    |   |
| 5         |                                                                                                                                                                                                                                                                             |        |          |       |        |           |       |               |           |             |           |      |      |      |      |      |          |              |          |        |       |          |          |           |     |    |     |     |   |   |    |     |   |    |     |    |    |   |
|           | Period o                                                                                                                                                                                                                                                                    | f Pr   | ofe      | ssio  | nal    | Pra       | ctice | e:            |           |             | fron      | n    | mo   |      | /_   | у    | r.       | _ t          | 0        | mo.    | /     | ′        | yr.      |           |     |    |     |     |   |   |    |     |   |    |     |    |    |   |
|           | Type of professional activity (include name and address of employer)                                                                                                                                                                                                        |        |          |       |        |           |       |               |           |             |           |      |      |      |      |      |          |              |          |        |       |          |          |           |     |    |     |     |   |   |    |     |   |    |     |    |    |   |
|           |                                                                                                                                                                                                                                                                             |        |          |       |        |           |       |               |           |             |           |      |      |      |      |      |          |              |          |        |       |          |          |           |     |    |     |     |   |   |    |     |   |    |     |    |    |   |
|           |                                                                                                                                                                                                                                                                             |        |          |       |        |           |       |               |           |             |           |      |      |      |      |      |          |              |          |        |       |          |          |           |     |    |     |     |   |   |    |     |   |    |     |    |    |   |
|           | Name o                                                                                                                                                                                                                                                                      | f de   | ntis     | t yo  | u ar   | e as      | skin  | g to          | се        | rtify       | this      | s pe | erio | d of | pro  | ofes | sio      | nal          | prac     | ctice: |       |          |          |           |     |    |     |     |   |   |    |     |   |    |     |    |    |   |
|           |                                                                                                                                                                                                                                                                             |        |          |       |        |           |       |               |           |             |           |      |      |      |      |      |          |              |          |        |       |          |          |           |     |    |     |     |   |   |    |     |   |    |     |    |    |   |
| 6         | 1 4- 1                                                                                                                                                                                                                                                                      |        | -1 ·     | · · · |        |           |       | - 1           |           |             |           |      |      | _    |      |      |          |              | i P      |        |       |          |          |           |     |    |     | - 1 | _ |   |    | _   |   |    |     |    |    |   |
|           | I declare<br>understa<br>and may                                                                                                                                                                                                                                            | and    | that     | t an  | y fa   | lse (     | or m  | isle          | eadi      | ng          |           |      |      |      |      |      |          |              |          |        |       |          |          |           |     |    |     |     |   |   |    |     |   |    |     |    |    |   |
|           |                                                                                                                                                                                                                                                                             |        |          |       |        |           |       |               |           |             |           |      |      |      |      |      |          |              |          |        |       |          |          |           |     |    |     |     | _ |   |    | _ / |   |    | _/_ |    |    | _ |
|           | Applicar                                                                                                                                                                                                                                                                    | ıt's 🤄 | Sigr     | natu  | re     |           |       |               |           |             |           |      |      |      |      |      |          |              |          |        |       |          |          |           |     |    |     |     |   | r | no |     | d | ay |     | yı | r. |   |
|           |                                                                                                                                                                                                                                                                             |        |          |       |        |           |       |               | Res       | stri        | cted      | ) De | enta | al F | acı  | ulty | Fo       | rm           | 4, P     | age    | 1 0   | f 2,     | , Ja     | nua       | ary | 20 | 009 |     |   |   |    |     |   |    |     |    |    |   |
|           |                                                                                                                                                                                                                                                                             |        |          |       |        |           |       |               |           |             |           |      |      |      |      |      |          |              |          |        |       |          |          |           |     |    |     |     |   |   |    |     |   |    |     |    |    |   |

| Section II: Affidavit of Pro  | ofessional Practice                                          |                                                                                                                                              |             |          |            |             |
|-------------------------------|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------|----------|------------|-------------|
| and sign an                   | d date the affirmation befo                                  | ng in the jurisdiction where the applicant practice of the sending the entire form to the Office of the epted if submitted by the applicant. |             |          |            |             |
|                               |                                                              |                                                                                                                                              |             |          |            |             |
| Name of applicant:            |                                                              |                                                                                                                                              |             |          |            |             |
|                               |                                                              | (Section I, item 3)                                                                                                                          |             |          |            |             |
|                               | of good moral character, and actice dentistry in the State o | recommend him/her to the State Board for Der<br>of New York.                                                                                 |             | the Dep  | partment a | as entirely |
| I have been personally acq    | uainted with the applicant for                               | r years.                                                                                                                                     |             |          |            |             |
| I have first-hand knowledge   | e that said applicant has prac                               | cticed as follows (attach additional sheets if nec                                                                                           | essary):    |          |            |             |
| Da                            | tes                                                          | <b>D</b>                                                                                                                                     |             |          |            |             |
| From<br>Month/Year            | To<br>Month/Year                                             | - Practice Loc                                                                                                                               | ation       |          |            |             |
|                               |                                                              |                                                                                                                                              |             |          |            |             |
|                               |                                                              |                                                                                                                                              |             |          |            |             |
|                               |                                                              |                                                                                                                                              |             |          |            |             |
|                               |                                                              |                                                                                                                                              |             |          |            |             |
|                               |                                                              |                                                                                                                                              |             |          |            |             |
|                               |                                                              |                                                                                                                                              |             |          |            |             |
| Affirmation                   |                                                              |                                                                                                                                              |             |          |            |             |
| I declare and affirm that the | e statements made in this ap                                 | plication, including accompanying documents, a                                                                                               | are true, c | omplete  | and corre  | ect.        |
| Signature:                    |                                                              |                                                                                                                                              | Date:       | /_       | /          |             |
| Print Name:                   |                                                              |                                                                                                                                              | n           | no.      | day        | yr.         |
| Jurisdiction where I am a li  | censed dentist in good stand                                 | ling:                                                                                                                                        |             |          |            |             |
| License number:               |                                                              |                                                                                                                                              |             |          |            |             |
| Address:                      |                                                              |                                                                                                                                              |             |          |            |             |
| Telephone                     |                                                              |                                                                                                                                              |             |          |            |             |
|                               |                                                              | Fax:                                                                                                                                         |             |          |            |             |
| E-mail:                       |                                                              |                                                                                                                                              |             |          |            |             |
|                               |                                                              | artment, Office of the Professions, Division o                                                                                               | of Profess  | ional Li | censing :  | Services,   |
| Dent                          |                                                              | Avenue, Albany, NY 12234-1000.                                                                                                               |             |          |            |             |
|                               | Restricted Denta                                             | al Faculty Form 4, Page 2 of 2, January 2009                                                                                                 |             |          |            |             |