

## Medical Physicist Form 4A Verification of Professional Experience

**You must submit a Form 4A for each endorser you list on Form 4.**

### Applicant Instructions

1. Complete Section I and sign and date item 10.
2. Send the entire Form 4A and a copy of the instructions to the endorser who will attest to your professional practice of medical physics and request that he/she complete Section II and return the entire form 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. You must complete a separate Form 4A for each specialty you are applying for.

Check what you are applying for (check one):  Diagnostic Radiological  Medical Health  Medical Nuclear  Therapeutic Radiological

### 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. Endorser's Name \_\_\_\_\_  
Experience described below was completed while employed by \_\_\_\_\_  
Organization Address \_\_\_\_\_

8. If licensed as a medical physicist in the United States, indicate jurisdiction? \_\_\_\_\_  
License number \_\_\_\_\_ Specialty area \_\_\_\_\_

9. Report of experience - Describe in the space below your medical physicist duties during your employment with the organization named above. Be as specific as possible describing tasks within the scope of practice of the specialty area of your application.  
Date beginning    Date ending    or  still employed by organization  
                            mo.    day    yr.                      mo.    day    yr.

Specialty area \_\_\_\_\_ Clock hours in a calendar year \_\_\_\_\_

10. Attestation. I hereby certify that the work experience described in item 9 and the time claimed for that experience are true and accurate and give permission to the endorser named in item 7 to complete the information in Section II of this form and send it to the Office of the Profession at the address at the end of the form.

Signature \_\_\_\_\_

Date \_\_\_\_\_

### Section II: Verification of Professional Experience - To be completed by Endorser

**Instructions to the Endorser:** Read carefully the applicant's Report of Experience in Section I and complete Section II. Be sure to sign and date the attestation. Return the entire form directly to the Office of the Professions at the address at the end of the form. **Do not return original to the applicant. This form will not be accepted if returned by the applicant.**

Name of the applicant \_\_\_\_\_

(see Section I, item 3)

1. I have been personally acquainted with the applicant named above for \_\_\_\_\_ years
2. I have first-hand knowledge that the applicant has completed \_\_\_\_\_ years, and \_\_\_\_\_ months of satisfactory professional experience as a medical physicist in the \_\_\_\_\_ specialty are, and that i am qualified to attest to the applicant's experience.

#### With respect to the applicant's report of experience:

3. Does the description in Section I accurately reflect the work personally performed by the applicant?  Yes  No
4. Does the time claimed by the applicant for this experience reasonably reflect actual time?  Yes  No
5. Was the experience claimed by the applicant obtained as part of a successfully completed CAMPEP accredited residency?  Yes  No
6. Briefly identify your work relationship to the applicant at the time (i.e. direct supervisor, department head, colleague or client etc.) If none, explain

### Attestation

I declare and affirm that I have read the "Instructions for Completing Verification of Professional Experience" form and that the statements herein are true, complete and correct, and that, to the best of my knowledge, the experience reflected here is the professional medical physics.

Signature of Registrar \_\_\_\_\_

Date \_\_\_\_\_

Print Name \_\_\_\_\_

Profession \_\_\_\_\_

License number \_\_\_\_\_

Jurisdiction \_\_\_\_\_

Address \_\_\_\_\_

If you disagree with any information presented by the applicant on this form, or 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 applicant by full name and social security number in your letter and indicate that he/she is an applicant.

Telephone \_\_\_\_\_

Fax \_\_\_\_\_

Email \_\_\_\_\_

Check here if you are attaching separate letter.

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