Credential Verification Service for New York State
Authorization for Verification of Academic Records/Transcripts

CGFNS International • P.O. Box 8628, Philadelphia, Pennsylvania 19104-8628 USA • Phone: +1 (215) 222 8454 extension 602 • Web: www.cgfns.org

Dear school official

I have applied to the New York State Education Department for licensure as a ______________________________. That department has authorized CGFNS International to obtain my official academic records/transcripts. Please send my official academic records/transcripts directly to CGFNS International. My information appears below.

My CGFNS ID number (if known) ______________________ Order number (if known) ______________________

My name when I attended your school, English spelling ______________________

My name when I attended your school, native language spelling ______________________

My current name (if different than above), English spelling ______________________

My current name (if different than above), native language spelling ______________________

The school where I received my post-secondary (tertiary) education, English spelling ______________________

The school where I received my post-secondary (tertiary) education, native language spelling ______________________

Attendance dates: From ______ / ______ (Month/Year) to ______ / ______ (Month/Year) My birth date ______ / ______ / ______ (Month / Day / Year)

School's current mailing address ______________________

____

My attestation

I hereby authorize CGFNS to obtain any and all documents and/or information regarding my academic records/transcripts. I also authorize CGFNS to disclose certain information about me to the New York State Education Department, to any person or organization that I designate in writing and any other recipient that CGFNS believes has a legitimate interest in receiving it (such as government agencies or potential employers). CGFNS may disclose the information and documents pertaining to my academic records/transcripts, the status of any reports, evaluations or verifications prepared by CGFNS, any other information obtained by CGFNS and the results and reasons for any action that CGFNS may take against me.

My signature ______________________ Date ______ / ______ / ______ (Month / Day / Year)

Revised April 2011

CGFNS INTERNATIONAL Global Credibility

Credential Verification Service for New York State

Authorization for Verification of Academic Records/Transcripts

CGFNS International • P.O. Box 8628, Philadelphia, Pennsylvania 19104-8628 USA • Phone: +1 (215) 222 8454 extension 602 • Web: www.cgfns.org

Dear school official

I have applied to the New York State Education Department for licensure as a ______________________________. That department has authorized CGFNS International to obtain my official academic records/transcripts. Please send my official academic records/ transcripts directly to CGFNS International. My information appears below.

My CGFNS ID number (if known) ________________ Order number (if known) ________________

My name when I attended your school, English spelling ______________________________

My name when I attended your school, native language spelling ______________________________

My current name (if different than above), English spelling ______________________________

My current name (if different than above), native language spelling ______________________________

The school where I received my post-secondary (tertiary) education, English spelling ______________________________

The school where I received my post-secondary (tertiary) education, native language spelling ______________________________

Attendance dates: From _____ / _____ (Month/Year) to _____ / _____ (Month/Year) My birth date _____ / _____ / _____ (Month / Day / Year)

School's current mailing address ______________________________

____

My attestation

I hereby authorize CGFNS to obtain any and all documents and/or information regarding my academic records/transcripts. I also authorize CGFNS to disclose certain information about me to the New York State Education Department, to any person or organization that I designate in writing and any other recipient that CGFNS believes has a legitimate interest in receiving it (such as government agencies or potential employers). CGFNS may disclose the information and documents pertaining to my academic records/transcripts, the status of any reports, evaluations or verifications prepared by CGFNS, any other information obtained by CGFNS and the results and reasons for any action that CGFNS may take against me.

My signature ______________________________ Date _____ / _____ / _____ (Month / Day / Year)

Revised April 2011

CVS

Credential Verification Service for New York State
Authorization for Validation of License/Registration

CGFNS International • P.O. Box 8628, Philadelphia, Pennsylvania 19104-8628 USA • Phone: +1 (215) 222 8454 extension 602 • Web: www.cgfns.org

Dear licensing authority

I have applied to the New York State Education Department for licensure as a ______________________. That department has authorized CGFNS International to obtain official validation of my license/registration. Please send an official validation of my license/registration directly to CGFNS International. My information appears below.

My CGFNS ID number (if known) ______________ Order number (if known) ______________

Licensing authority's name ______________

Licensing authority's address ______________

____

My current name, English spelling ______________

My current name, native language spelling ______________

My license/registration was issued under the name (if different than above), English spelling ______________

My license/registration was issued under the name (if different than above), native language spelling ______________

My license/registration number ______________ My birth date ____ / ____ / ____
Month Day Year

The school where I received my post-secondary (tertiary) education, English spelling ______________

The school where I received my post-secondary (tertiary) education, native language spelling ______________

Attendance dates: From ______________ to ______________
Month/Year Month/Year

My country/citizen identification number (if applicable) ______________

My attestation

I hereby authorize CGFNS to obtain any and all documents and/or information regarding my license/registration. I also authorize CGFNS to disclose certain information about me to the New York State Education Department, to any person or organization that I designate in writing and any other recipient that CGFNS believes has a legitimate interest in receiving it (such as government agencies or potential employers). CGFNS may disclose the information and documents pertaining to my license/registration , the status of any reports, evaluations or verifications prepared by CGFNS, any other information obtained by CGFNS and the results and reasons for any action that CGFNS may take against me.

My signature ______________ Date ____ / ____ / ____
Month Day Year

Revised April 2011

Credential Verification Service for New York State
Authorization for Validation of License/Registration

CGFNS International • P.O. Box 8628, Philadelphia, Pennsylvania 19104-8628 USA • Phone: +1 (215) 222 8454 extension 602 • Web: www.cgfns.org

Dear licensing authority

I have applied to the New York State Education Department for licensure as a ______________________________. That department has authorized CGFNS International to obtain official validation of my license/registration. Please send an official validation of my license/registration directly to CGFNS International. My information appears below.

My CGFNS ID number (if known) ____________ Order number (if known) ____________

Licensing authority's name ______________________________

Licensing authority's address ______________________________

____

My current name, English spelling ______________________________

My current name, native language spelling ______________________________

My license/registration was issued under the name (if different than above), English spelling ______________________________

My license/registration was issued under the name (if different than above), native language spelling ______________________________

My license/registration number ____________ My birth date ______ / ______ / ______
Month Day Year

The school where I received my post-secondary (tertiary) education, English spelling ______________________________

The school where I received my post-secondary (tertiary) education, native language spelling ______________________________

Attendance dates: From ____________ to ____________
Month/Year Month/Year

My country/citizen identification number (if applicable) ______________________________

My attestation

I hereby authorize CGFNS to obtain any and all documents and/or information regarding my license/registration. I also authorize CGFNS to disclose certain information about me to the New York State Education Department, to any person or organization that I designate in writing and any other recipient that CGFNS believes has a legitimate interest in receiving it (such as government agencies or potential employers). CGFNS may disclose the information and documents pertaining to my license/registration , the status of any reports, evaluations or verifications prepared by CGFNS, any other information obtained by CGFNS and the results and reasons for any action that CGFNS may take against me.

My signature ______________________________ Date ______ / ______ / ______
Month Day Year

Revised April 2011

14 Terms and Conditions of the CGFNS Credential Verification Service for New York State

This section clarifies CGFNS's obligations and your obligations regarding the Credential Verification Service for New York State. It also explains how this service is delivered.

- CGFNS may choose to review only the documents it considers relevant to this application.
- Verification will not be performed until CGFNS receives a completed, signed and notarized* application, full payment and appropriate authorization forms.
- Fees are subject to change and are found at http://www.cgfns.org/sections/apply/fees.shtml#4
- Any payment sent to CGFNS will be applied first to any unpaid balance from previous orders for products or services before it is applied as payment for a newer order.
- The response time for Canadian applicants is limited to 90 days. For all other countries it is limited to 180 days. When the response time has elapsed a final review is performed and a report is prepared and sent to the New York State Education Department.
- If you would like to be verified for New York State for another occupation, you will have to complete an entirely new application.
- No refund is given after an application is submitted.
- Documents that CGFNS receives for its other services cannot be used for the Credential Verification Service for New York State.
- **If your application has been forged, altered or falsified, that information will be provided in the report to** the New York State Education Department**.**

* Authenticated, legalized or notarized by the country's approved channels for authentication

15 Attestation

Please note: Each applicant must sign his/her full name in English on the applicant's signature line.

I certify that all information which CGFNS has received as part of this application or in the past, from me or from a third party on my behalf, is true and complete. I also certify that all documents which have been submitted to CGFNS for any purpose have not been falsified, altered or tampered with by any person.

I understand that CGFNS and others will rely on this application and on the documents and information submitted, and that if any of it is falsified, altered or tampered with, or if I misrepresent a copy as an original, CGFNS may take action against me as it deems appropriate, including barring me from participation in any CGFNS programs or to otherwise take action against me as appropriate. The consequences could adversely affect my professional license, immigration status, employment and other matters, from which I release CGFNS from all liability.

I authorize CGFNS to disclose the information and documents in this application, the status of any reports or evaluations prepared by CGFNS, any other information obtained by CGFNS and the results and reasons for any adverse action taken against me by CGFNS, to any person or organization I designate in writing or to any other recipient which CGFNS may determine has a legitimate interest in receiving the same, such as government agencies or potential employers.

You must sign and date this application in order for it to be processed.

Your signature ______________________ CGFNS ID number ______________________
Sign entire name

Print your name ______________________ Date ______________________
Month / Day / Year

Notary (authenticating official) signature ______________________
Sign entire name

Print name of notary ______________________ Date ______________________
Month / Day / Year

Mail the completed application and payment to CGFNS International, PO Box 8628, Philadelphia, PA 19104-8628 USA

©Copyright 2009–2011 CGFNS. All rights reserved.

22 **CHILD ABUSE IDENTIFICATION AND REPORTING COURSEWORK REQUIREMENT** – RN Applicants Only (check one):

- ☐ I graduated from a NYS registered nursing program after September 1, 1990 and completed the coursework during my studies.
- ☐ I completed the child abuse coursework and have enclosed a certificate of completion from an approved provider.
- ☐ I completed the child abuse coursework online and the approved provider will report that to you electronically.
- ☐ I am filing for an exemption to the requirement and have enclosed the Certification of Exemption (Form 1CE*).

*Form 1CE is available on the Office of the Professions' Web site at www.op.nysed.gov/documents/form1ce.pdf.

23 **INFECTION CONTROL TRAINING REQUIREMENT** (check one):

- ☐ I graduated from a NYS registered nursing program after September 1, 1993 and completed the infection control training during my studies.
- ☐ I completed the infection control training and have enclosed a certificate of completion from an approved provider.
- ☐ I completed the infection control training online and the approved provider will report that to you electronically.
- ☐ I am filing for an exemption to the requirement and have enclosed an Attestation of Infection Control Training (Form 1IC*).

*Form 1IC is available on the Office of the Professions' Web site at www.op.nysed.gov/documents/form1ic.pdf.

24 **EDUCATION PROGRAM REVIEW**

I give permission to the New York State Education Department to release my examination results to my professional school for the confidential purposes of program review and institution research and planning. I may rescind this authority at any time by notifying the Division of Professional Licensing Services in writing.

☐ Yes ☐ No

Please initial: _________________________

25 **GENDER AND ETHNICITY: (This item is optional.)**

Information on gender and ethnicity is sought solely to allow the New York State Education Department to collect and analyze data concerning diversity in the licensed professions. The ethnic and gender data you provide will be used only for statistical, research, and program evaluation purposes. It will not be released to the public. This information has absolutely no bearing on your qualification for licensure.

GENDER: ☐ Male ☐ Female

ETHNICITY: ☐ White (not Hispanic) ☐ Black (not Hispanic) ☐ Asian ☐ Hispanic ☐ Native American

26 **AFFIDAVIT WITH ACKNOWLEDGMENT** (Notarization required.)

Applicant

I 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's signature ____ Date _______ / _______ / _______
Month Day Year

Notary

State of ____ County of ____

On the ____________ day of ______________________ in the year __________ before me, the undersigned, personally appeared ___________________________, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public's signature ____

Notary ID number ________________________________

Expiration date ________ / ________ / ________
Month Day Year

Notary Stamp

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, PO Box 22063, Albany, NY 12201. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.

Form 1CE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

CERTIFICATION OF EXEMPTION

IDENTIFICATION AND REPORTING CHILD ABUSE and MALTREATMENT TRAINING

Applicants for licensure and licensees applying for re-registration as **physicians, chiropractors, dentists, registered nurses, podiatrists, optometrists, psychologists, dental hygienists, licensed master social workers, licensed clinical social workers, creative arts therapists, marriage and family therapists, mental health counselors, and psychoanalysts** must complete two hours of Department approved coursework or training in the identification and reporting of child abuse and maltreatment. A limited exemption from this requirement is available if the nature of the applicant's/licensee's practice excludes contact with children. Any licensee who asks for an exemption must notify the Department in writing, within 30 days, when the nature of the practice changes and an exemption is no longer valid.

APPLICANT INSTRUCTIONS

1. If you are certain that you qualify for an exemption, complete items 1-6 by printing clearly in ink in the spaces provided. Be sure to sign and date Item 7
2. Send the completed form to the address shown above to the attention of the unit for your profession (for example: Attention Medicine Unit). See item 6 for listing.

Properly completed forms will be accepted. You will only receive notice from the Department if a request is insufficient to grant an exemption. Please retain a photocopy of this Certification of Exemption.

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 Your Name Exactly As It Appears On Your Licensure Application Or Registration**

Last

First

Middle

4 **Mailing Address** (You must notify the Department promptly of any address or name changes.)

Line 1

Line 2

Line 3

City

State Zip Code

Country/
Province

5 **N.Y.S. License Number**
(If applicable)

6 **Profession** *(check one)*

- ☐ Medicine
- ☐ Chiropractic
- ☐ Dentistry
- ☐ Dental Hygiene
- ☐ Registered Nurse
- ☐ Podiatry
- ☐ Optometry
- ☐ Psychology
- ☐ Licensed Master Social Worker
- ☐ Licensed Clinical Social Worker
- ☐ Creative Arts Therapist
- ☐ Marriage and Family Therapist
- ☐ Mental Health Counselor
- ☐ Psychoanalyst

7 **ATTESTATION**

59.12 (b) The department may exempt an applicant or licensee from the coursework or training requirement of subdivision (a) of this section upon receipt of a written application for such exemption establishing that there would be no need to complete the coursework or training because the nature of the applicant's/licensee's practice excludes contact with children. It is the professional responsibility of the licensee who holds an exemption to notify the department in writing, within 30 days, when the nature of the practice changes to the extent that the basis for exemption ceases to exist.

I, the undersigned, have read regulation 59.12(b) above and the explanation on this form. I understand the terms and conditions contained therein, and hereby declare that the nature of my practice is such that I do not treat or otherwise have professional contact either with children under the age of 18 years or persons 18 years of age and older with a handicapping condition who reside in a residential care school or facility. Therefore, I claim an exemption from the required training in child abuse and maltreatment identification and reporting pursuant to Section 59.12, Regulations of the Commissioner.

I also understand that should the nature of my practice change to the extent that the basis for the exemption ceases to exist, I am obligated to notify the department in writing and complete the required training within 30 days.

I further understand that a false statement on this document may be cause for denial or loss of licensure and may result in criminal prosecution.

Applicant signature *Date*

Form 1CE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

CERTIFICATION OF EXEMPTION

IDENTIFICATION AND REPORTING CHILD ABUSE and MALTREATMENT TRAINING

Applicants for licensure and licensees applying for re-registration as **physicians, chiropractors, dentists, registered nurses, podiatrists, optometrists, psychologists, dental hygienists, licensed master social workers, licensed clinical social workers, creative arts therapists, marriage and family therapists, mental health counselors, and psychoanalysts** must complete two hours of Department approved coursework or training in the identification and reporting of child abuse and maltreatment. A limited exemption from this requirement is available if the nature of the applicant's/licensee's practice excludes contact with children. Any licensee who asks for an exemption must notify the Department in writing, within 30 days, when the nature of the practice changes and an exemption is no longer valid.

APPLICANT INSTRUCTIONS

1. If you are certain that you qualify for an exemption, complete items 1-6 by printing clearly in ink in the spaces provided. Be sure to sign and date Item 7
2. Send the completed form to the address shown above to the attention of the unit for your profession (for example: Attention Medicine Unit). See item 6 for listing.

Properly completed forms will be accepted. You will only receive notice from the Department if a request is insufficient to grant an exemption. Please retain a photocopy of this Certification of Exemption.

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 Your Name Exactly As It Appears On Your Licensure Application Or Registration**

Last

First

Middle

4 **Mailing Address** (You must notify the Department promptly of any address or name changes.)

Line 1

Line 2

Line 3

City

State Zip Code

Country/ Province

5 **N.Y.S. License Number**
(If applicable)

6 **Profession** *(check one)*

- ☐ Medicine
- ☐ Chiropractic
- ☐ Dentistry
- ☐ Dental Hygiene
- ☐ Registered Nurse
- ☐ Podiatry
- ☐ Optometry
- ☐ Psychology
- ☐ Licensed Master Social Worker
- ☐ Licensed Clinical Social Worker
- ☐ Creative Arts Therapist
- ☐ Marriage and Family Therapist
- ☐ Mental Health Counselor
- ☐ Psychoanalyst

7 **ATTESTATION**

59.12 (b) The department may exempt an applicant or licensee from the coursework or training requirement of subdivision (a) of this section upon receipt of a written application for such exemption establishing that there would be no need to complete the coursework or training because the nature of the applicant's/licensee's practice excludes contact with children. It is the professional responsibility of the licensee who holds an exemption to notify the department in writing, within 30 days, when the nature of the practice changes to the extent that the basis for exemption ceases to exist.

I, the undersigned, have read regulation 59.12(b) above and the explanation on this form. I understand the terms and conditions contained therein, and hereby declare that the nature of my practice is such that I do not treat or otherwise have professional contact either with children under the age of 18 years or persons 18 years of age and older with a handicapping condition who reside in a residential care school or facility. Therefore, I claim an exemption from the required training in child abuse and maltreatment identification and reporting pursuant to Section 59.12, Regulations of the Commissioner.

I also understand that should the nature of my practice change to the extent that the basis for the exemption ceases to exist, I am obligated to notify the department in writing and complete the required training within 30 days.

I further understand that a false statement on this document may be cause for denial or loss of licensure and may result in criminal prosecution.

Applicant signature *Date*

Form 1IC

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
Registration/Fee Unit
89 Washington Avenue
Albany, NY 12234-1000

ATTESTATION OF INFECTION CONTROL TRAINING

INSTRUCTIONS

Complete Items 1-8 and return this form to the address printed above. Keep a photocopy of this completed and signed form with other pertinent documentation (i.e. copy of any course completion certificate) in your personal files.

1 SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐

(Leave this blank if you do not have a U.S. Social Security Number)

2 BIRTH DATE ☐☐ ☐☐ ☐☐

mo . day yr.

3 PRINT FULL NAME EXACTLY AS IT APPEARS ON YOUR APPLICATION

Last

First

Middle

4 LICENSE NUMBER ☐ ☐☐☐☐☐☐-☐

5 ADDRESS

Apt./Bldg.

Street

City

State

Zip Code

Province/Country If not U.S.

6 CHECK YOUR PROFESSION

- ☐ DENTISTRY
- ☐ DENTAL HYGENE
- ☐ LIC. PRACT. NURSING
- ☐ REG. PROF. NURSING
- ☐ NURSE PRACTITIONER
- ☐ OPTOMETRY
- ☐ PODIATRY

7 **INFECTION CONTROL TRAINING**

Complete **either** section 1 or section 2 below:

Section 1. COMPLIANCE BY COMPLETION OF APPROVED COURSE WORK.

☐ Within the four years prior to the date of this attestation I completed approved infection control course work appropriate to my professional practice given by:

_______________________________________ ____ / ____ / ____

Provider name *mo. day yr.*

Section 2. EXEMPTION BASED ON LOCATION, NATURE OF PRACTICE, OR EQUIVALENT COURSE WORK. (check one)

☐ (a) I will not be engaged in the practice of my profession within New York State during the period indicated on my registration application.

OR

☐ (b) The nature of my practice does not require the use of infection control techniques or barrier precautions.

I understand that, if I return to my professional practice in New York State or change the nature of my practice thus requiring the use of infection control techniques, I will inform the Education Department in writing within 30 days and, within 90 days of the change in practice, both obtain the required course work and notify the Department of my compliance with this requirement.

OR

☐ (c) **I am exempt** from the infection control course work requirement for the duration of my next registration period **because**, within the four years prior to the date of this attestation, **I completed infection control course work appropriate to my professional practice that covered all six core elements cited in the instructions**. I will maintain, for the next four years, documentation of the infection control course content, including syllabi and curricular materials, and, if training was taken outside a professional program, a certification of course work completion that is dated and signed by the provider. I completed this course work given by:

_______________________________________ ____ / ____ / ____

Provider name *mo. day yr.*

8 **I swear that this attestation is true and I understand that any false statement may be considered fraud or perjury and a form of professional misconduct which will result in disciplinary action against my professional license by the New York State Education Department.**

_______________________________________ ____ / ____ / ____

Signature *mo. day yr.*

Form 1IC

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
Registration/Fee Unit
89 Washington Avenue
Albany, NY 12234-1000

ATTESTATION OF INFECTION CONTROL TRAINING

INSTRUCTIONS

Complete Items 1-8 and return this form to the address printed above. Keep a photocopy of this completed and signed form with other pertinent documentation (i.e. copy of any course completion certificate) in your personal files.

1 SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐

(Leave this blank if you do not have a U.S. Social Security Number)

2 BIRTH DATE ☐☐ ☐☐ ☐☐

mo . day yr.

3 PRINT FULL NAME EXACTLY AS IT APPEARS ON YOUR APPLICATION

Last

First

Middle

4 LICENSE NUMBER

☐ ☐☐☐☐☐☐-☐

5 ADDRESS

Apt./Bldg.

Street

City

State

Zip Code

Province/Country If not U.S.

6 CHECK YOUR PROFESSION

- ☐ DENTISTRY
- ☐ DENTAL HYGENE
- ☐ LIC. PRACT. NURSING
- ☐ REG. PROF. NURSING
- ☐ NURSE PRACTITIONER
- ☐ OPTOMETRY
- ☐ PODIATRY

7 **INFECTION CONTROL TRAINING**

Complete **either** section 1 or section 2 below:

Section 1. COMPLIANCE BY COMPLETION OF APPROVED COURSE WORK.

☐ Within the four years prior to the date of this attestation I completed approved infection control course work appropriate to my professional practice given by:

_______________________________________ ____ / ____ / ____

Provider name *mo. day yr.*

Section 2. EXEMPTION BASED ON LOCATION, NATURE OF PRACTICE, OR EQUIVALENT COURSE WORK. (check one)

☐ (a) I will not be engaged in the practice of my profession within New York State during the period indicated on my registration application.

OR

☐ (b) The nature of my practice does not require the use of infection control techniques or barrier precautions.

I understand that, if I return to my professional practice in New York State or change the nature of my practice thus requiring the use of infection control techniques, I will inform the Education Department in writing within 30 days and, within 90 days of the change in practice, both obtain the required course work and notify the Department of my compliance with this requirement.

OR

☐ (c) **I am exempt** from the infection control course work requirement for the duration of my next registration period **because**, within the four years prior to the date of this attestation, **I completed infection control course work appropriate to my professional practice that covered all six core elements cited in the instructions**. I will maintain, for the next four years, documentation of the infection control course content, including syllabi and curricular materials, and, if training was taken outside a professional program, a certification of course work completion that is dated and signed by the provider. I completed this course work given by:

_______________________________________ ____ / ____ / ____

Provider name *mo. day yr.*

8 **I swear that this attestation is true and I understand that any false statement may be considered fraud or perjury and a form of professional misconduct which will result in disciplinary action against my professional license by the New York State Education Department.**

_______________________________________ ____ / ____ / ____

Signature *mo. day yr.*