Form 1CE															,			State											
THE STATE EDUCATION DEPARTMENT Office of the Professions Division of Professional Licensing Services																													
www.op.nysed.gov																													
CERTIFICATION OF EXEMPTION																													
IDENTIFICATION AND REPORTING CHILD ABUSE and MALTREATMENT TRAINING																													
Applicants for licensure and licensees applying for re-registration as <b>Certified Behavior Analyst Assistants</b> , <b>Chiropractors</b> , <b>Creative Arts Therapists</b> , <b>Dental Hygienists</b> , <b>Dentists</b> , <b>Licensed Behavior Analysts</b> , <b>Licensed Clinical Social Workers</b> , <b>Licensed Master Social Workers</b> , <b>Marriage and Family Therapists</b> , <b>Mental Health Counselors</b> , <b>Optometrists</b> , <b>Physicians</b> , <b>Podiatrists</b> , <b>Psychoanalysts</b> , <b>Psychologists</b> , <b>and Registered Nurses</b> 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must notify the Department in writing, within 30 days, when the nature of the practice changes and an exemption is no longer valid.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																												
<ol> <li>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.</li> <li>Send the completed form to the address at the end of the form to the attention of the unit for your profession (for example: Attention Medicine Unit). See item 6 for listing.</li> </ol>																													
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)       5       N.Y.S. License Number (If applicable)																													
2 Birth	Dat	е	Μ	lontł	h			Day	,	] Y	ear																		
3 Print Your Name Exactly As It Appears On Your Licensure Application Or Registration 6 Profession (check one)																													
Last																	]								L		_	ertified Behavior Analyst Assista	int
First	Γ		T				Ī	Ť			]		•			-	-										_	hiropractor reative Arts Therapist	
Middle		T	Ť	T			F	Ŧ	Ē		]																_	ental Hygienist	
4 Mailin																													
Line 1	.g /		T					T					.p,								T		0.)			_		icensed Clinical Social Worker icensed Master Social Worker	
Line 1	$\vdash$		<u> </u>				Ē	$\vdash$	$\frac{1}{1}$										$\frac{1}{1}$		<u> </u>							larriage and Family Therapist	
	F	+	$\frac{1}{1}$	+			F	╞	$\vdash$			+		_					$\frac{1}{1}$	<u> </u>	1	=					_	ledicine lental Health Counselor	
Line 3	F	$\frac{1}{1}$	$\frac{1}{1}$	+				$\vdash$	<u> </u>			+	+					$\frac{1}{1}$	$\frac{1}{1}$	+							_	ptometrist	
City		-	Ļ									_	4					-	Ļ									odiatrists	
State Country/		_	1				Zip	Cod	e 			4							_			_						sychoanalyst sychologist	
Province																											]R	egistered Nurse	
7 ATTESTATION																													
<b>59.12 (b)</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.																													
Applie	Applicant signature     Date						_																						
Mail the co	mpl	etec	l fo	orm	to:						ation ıe, Al							the F	Prof	essi	ion	s, D	ivisio	on of	Profe	essi	iona	al Licensing Services,	
Certification of Exemption Form 1CE, Rev. 12/14																													

The University of the State of New York The State Education Department Office of the Professions Division of Professional Licensing Services

## Form 1IC Attestation of Infection Control Training

Division of Professional Licensing Service www.op.nysed.gov	Attestation of Infection Control Training													
	Instructions													
	and date item 8. Submit the completed form along with any other required documentation (i.e. copy of any address at the end of the form. Make sure to keep a photocopy of this form for your personal files.													
1. Social Security Number (Leave this blank if you do not have	2. Birth Date Month Day Year Year													
3. Print Name Last														
First	$\frac{1}{1} \cdot \frac{1}{1} \cdot \frac{1}$													
Middle	5. License Number													
	email address are public information. Failure to													
	a for each item will deem it public information. 6. Check your profession													
4. Mailing Address 🗌 Home or	Business Dental Hygiene													
(You must notify the Departmen	t promptly of any address or name changes)													
Line 1	Licensed Practical Nursing													
Line 2	Nurse Practitioner													
Line 3														
City														
State ZIP Code														
Country/ Province														
Section I - Compliance by Cor	nplete either Section I or II below.) npletion of Approved Coursework ne date of this attestation, I completed approved infection control coursework appropriate to my professional practice Date													
Ocation II. Example Provide	mo. day yr.													
<ul> <li>a. I will not be engaged in the anture of my practice.</li> <li>b. The nature of my practice.</li> <li>I understand that, if I retuce control techniques. I will in required coursework and</li> <li>c. I am exempt from the infiprior to the date of this at</li> </ul>	<ul> <li>bn Location, Nature of Practice, or Equivalent Course Work (Check only one)</li> <li>e practice of my profession within New York State during the period indicated on my registration application.</li> <li>does not require the use of infection control techniques or barrier precautions.</li> <li>n to my professional practice in New York State or change the nature of my practice thus requiring the use of infection form the Education Department in Writing within 30 days and, within 90 days of the change in practice, both obtain the notify the Department of my compliance with this requirement.</li> <li>ection control coursework requirement for the duration of my next registration period because, within the four years estation, I completed infection control coursework appropriate to my professional practice that covered all and in the instructions. I will maintain, for the next four years, documentation of the infection control course content,</li> </ul>													
including syllabi and curr that is dated and signed	bular materials, and, if training was taken outside the professional program, a certification of coursework completion by the provided. I completed this coursework given by:													
Provider name	Date													
	mo. day yr. e and I understand that any false statement may be considered fraud or perjury and a form of vill result in disciplinary action against my professional license by the New York State Education													
Signature	Date													
Return Directly to: New York State and Fee Unit, 89 Washington Avenu	Education Department, Office of the Professions, Division of Professional Licensing Services, Registration Albany, NY 12234-1000.													