

9 Attestation

I declare and affirm that the statements made in the foregoing application are true, complete and correct. Any false or misleading information in, or in connection with, my application may be cause for denial of permit and licensure and may result in criminal prosecution.

Applicant's Signature _____ / _____ / _____
mo. day yr.

Section II: Certification of Supervision

Instructions to Supervisor: Complete this Section to certify that the applicant named below will be under your direction and supervision. For licensed behavior analysts, the supervisor must be a licensed behavior analyst or an a person who is licensed or otherwise authorized to diagnose, prescribe or order applied behavior analysis services for the purpose of providing behavioral health treatment to persons with autism and autism spectrum disorders and related disorders. For certified behavior analyst assistants, the supervisor must be a licensed behavior analyst. The applicant may not practice applied behavior analysis until the limited permit is issued. Limited permits expire one year from the date of issue and may be renewed for one additional year for good cause as determined by the Department.

Applicant's name: _____

Practice setting name: _____

Street: _____

City: _____ State: _____ Zip code: _____

Telephone: _____ Fax: _____ E-mail: _____

Supervisor

Name: _____

I am a licensed: _____
Professional Title

License number: _____ Date license issued: _____ Jurisdiction: _____

Supervisor Attestation

I certify that the applicant named in Section I will be employed under my supervision practicing applied behavior analysis for the sole purpose of providing behavioral health treatment to persons with autism and autism spectrum disorders and related disorders, pursuant to a diagnosis and prescription or order from a person who is licensed or otherwise authorized to provide such diagnosis and prescription or ordering of services. I declare and affirm that the information provided in the foregoing certification is true, complete and correct. Any false or misleading information in, or in connection with this certification may be cause for disciplinary action against my license.

Signature: _____ Date: _____ / _____ / _____
mo. day yr.

Print name : _____

Address: _____

Phone: _____ Fax: _____

E-mail: _____

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.