Restricted Dental Faculty Form 2

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

Certification of Professional Education

Applicant Instructions

1. 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 9.
2. Send the entire form to the institution(s) you attended and ask the registrar to complete Section II and forward both pages of the form directly to the Office of the Professions at the address at the end of this form. Be sure to include any fee required by the institution. **This form will not be accepted if submitted by the applicant.**
3. An official transcript or marksheets are required if you completed a program that is not registered by the Department as licensure qualifying at the time of your graduation.

Section I: Applicant Information

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 Name as It Appears on Your Application for Licensure (Form 1)**

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 Print your name as it appears on your degree or diploma.

Name: _____

6 School attended: _____
(Name) *(city/state or country)*

7 Name of degree/diploma: _____

8 Date degree/diploma awarded: _____ / _____ / _____
mo. day yr.

9 I request and give my permission to the school listed in item 6 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for licensure.

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

Section II: Certification of Education

Instructions to Registrar: Please complete Section II and return both pages of this form directly to the New York State Education Department at the address at the end of this form. **This form will not be accepted if returned by the applicant.**

Note: Non-registered or non-accredited programs must attach a transcript listing all courses taken by the applicant at the dental school and grades the applicant received. Also, attach a transcript of all courses convalidated or accepted for transfer credit by your dental school and the basis on which these subjects were convalidated, including the name of the institution from which credit was transferred.

1. Name of applicant: _____
   (Section I, item 5)
2. Completed satisfactorily, prior to matriculation in professional school, at least sixty hours of satisfactory post-secondary study, including courses in physics, biology or zoology, chemistry, and organic chemistry. ☐ Yes ☐ No

   Name of college(s) in which pre-professional study was completed:

   _____

   _____
3. Date of applicant's entrance, date of completion of studies or withdrawal from the dental school:

   Entrance date: _____ / _____ / _____ (mo. day yr.) Completion/withdrawal date: _____ / _____ / _____ (mo. day yr.)
4. Degree/diploma conferred: _____ Date awarded: _____ / _____ / _____ (mo. day yr.)
5. Dental Program was _____ years or _____ months.
6. **For schools outside the U.S.:**

   Did the program have a social service requirement for graduation? ☐ Yes ☐ No

   If yes, give dates and name of institution/facility in which requirement was met.

   Institution: _____ Dates from: _____ (mo./yr.) to: _____ (mo./yr.)

   Dental school: _____

   Name of student as it appears on school records: _____

Certification

I hereby certify that to the best of my knowledge and belief the information in Section II is a true statement of the record of the professional education of the individual named on this form.

Signature of Registrar: _____ Date: _____ / _____ / _____ (*mo. day yr.*)

Title or official position: _____

Institution: _____

Address: _____ **(SEAL)**

City: _____ State _____ Zip Code _____

Telephone: _____ Fax: _____

E-mail Address: _____

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