Medical Physicist Form 4

- ☐ **Diagnostic Radiological**
- ☐ **Medical Health**
- ☐ **Medical Nuclear**
- ☐ **Therapeutic Radiological**

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

PERSONAL AFFIDAVIT OF PROFESSIONAL EXPERIENCE

APPLICANT INSTRUCTIONS

Please complete this form in ink and return it to the Office of the Professions at the mailing address at the end of this form. Be sure to sign and date item 6. You should transcribe the professional experience information, including a comprehensive description of their professional experience, from the Form 4 to an individual Form 4A for each endorser you list (see Form 4A Instructions).

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 Full Name Exactly As It Appears On Your Licensure Application (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 Provide a chronological list of all medical physicist work experience. In the left column, provide dates and last name of endorser. In right column, provide type of professional experience including name and address of employer/supervisor and the primary site of the experience.

Exact dates (mo./day/yr.)	Type of professional experience including name and address of employer/supervisor
Endorser ________________ _____ / _____ / _____ to _____ / _____ / _____	Specialty area(s): ________________
Endorser ________________ _____ / _____ / _____ to _____ / _____ / _____	Specialty area(s): ________________
Endorser ________________ _____ / _____ / _____ to _____ / _____ / _____	Specialty area(s): ________________

PROFESSIONAL EXPERIENCE CONTINUED

Exact dates (mo./day/yr.)	Type of experience including name and address of employer/supervisor
Endorser ________________ _____ / _____ / _____ to _____ / _____ / _____	Specialty area(s): ______________________
Endorser ________________ _____ / _____ / _____ to _____ / _____ / _____	Specialty area(s): ______________________
Endorser ________________ _____ / _____ / _____ to _____ / _____ / _____	Specialty area(s): ______________________
Endorser ________________ _____ / _____ / _____ to _____ / _____ / _____	Specialty area(s): ______________________
Endorser ________________ _____ / _____ / _____ to _____ / _____ / _____	Specialty area(s): ______________________
Endorser ________________ _____ / _____ / _____ to _____ / _____ / _____	Specialty area(s): ______________________
Endorser ________________ _____ / _____ / _____ to _____ / _____ / _____	Specialty area(s): ______________________

6 ATTESTATION

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.

Signature of applicant: ____

Date: ______________________

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