Massage Therapist Form 4

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

REPORT OF PROFESSIONAL EXPERIENCE

- FOR ENDORSEMENT APPLICANTS ONLY -

APPLICANT INSTRUCTIONS

Use this form only if you are licensed in another state, province or country and are seeking licensure by endorsement.

1. Complete Section I in ink. Be sure to sign and date the attestation and send the form to the Office of the Professions at the address at the end of the form.
2. Provide a chronological list of all massage therapy work experience with the name and address of an employer, supervisor, coworker or colleague who will attest to that experience in Section II. Provide the number of corresponding periods of experience on Form 4B as appropriate. Attach additional sheets if necessary.

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 YOUR NAME EXACTLY AS IT APPEARS ON YOUR LICENSURE APPLICATION (FORM 1)

Last

First

Middle

4 MAILING ADDRESS

Line 1

Line 2

Line 3

City

State Zip Code

Country/ Province

SECTION II: PROFESSIONAL EXPERIENCE

No.	Exact dates (mo./day/yr.)	Type of experience including name and address of employer, supervisor, coworker or colleague.
1	_____ / _____ / _____ to _____ / _____ / _____	
2	_____ / _____ / _____ to _____ / _____ / _____	
3	_____ / _____ / _____ to _____ / _____ / _____	

PROFESSIONAL EXPERIENCE RECORD CONTINUED

No.	Exact dates (mo./day/yr.)	Type of experience including name and address of employer, supervisor, coworker or colleague.
4	_____ / _____ / _____ to _____ / _____ / _____	
5	_____ / _____ / _____ to _____ / _____ / _____	
6	_____ / _____ / _____ to _____ / _____ / _____	
7	_____ / _____ / _____ to _____ / _____ / _____	
8	_____ / _____ / _____ to _____ / _____ / _____	
9	_____ / _____ / _____ to _____ / _____ / _____	
10	_____ / _____ / _____ to _____ / _____ / _____	

ATTESTATION

I hereby certify that the work experience time claimed and the information provided is true, accurate and complete.

_____ _____
Applicant signature Date

_____ _____
Telephone Fax

_____
E-mail

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