FORM 4B

DENTAL HYGIENIST

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

VERIFICATION OF PROFESSIONAL PRACTICE

APPLICANT INSTRUCTIONS

Please Note: Only applicants who are licensed in another state need to complete this form. See instructions for additional information. The Office of the Professions will accept this form only if it is submitted directly by the licensed dentist who completed the form.

Complete Section I in ink. Sign and date item 6 and send this form to the licensed dentist(s) to complete Section II verifying your practice. If more than one dentist is verifying your practice, make copies of this form.

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 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 Name of dentist verifying practice (*please type or print*):

____

Dates worked: ________ / ________ / ________ to ________ / ________ / ________
Month Day Year *Month Day Year*

6 I request and give my permission to the licensed dentist completing Section II to complete the information on this form and send any documentation requested to the New York State Education Department.

Applicant's signature: ______________________________ Date: _____ / _____ / _____
Mo. Day Yr.

SECTION II

INSTRUCTIONS: A duly licensed dentist in good standing in the state where the applicant is licensed must complete the form and return it directly to the Office of the Professions at the address below. This form will not be accepted if submitted by the applicant.

1 **I have been personally acquainted** with the applicant named in Section I for _____ years.

2 I know him/her to be of good moral character, and recommend him/her to be licensed to practice dental hygiene in the State of New York. I know that said applicant has practiced dental hygiene as follows:

Date		Address (Where applicant practiced)
From	To	

3 **ATTESTATION**

I declare and affirm that the statements above are true, complete and correct.

Signature of dentist _____ Date _____

Print name: _____

License number_____ State in which you are licensed: _____

Address: _____

Telephone: _____ Fax: _____ E-mail: _____

RETURN DIRECTLY TO: ⟶

New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Dental Hygiene Unit, 89 Washington Avenue, Albany, NY 12234-1000