FORM 3A

MEDICINE

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

NOTE: Licensure in another jurisdiction is not a requirement for licensure in New York State; however, we require verification of current status from every jurisdiction in another country in which you have been licensed and/or practiced within the past five years.

Verification of Medical Licensure in Another Country

Applicant Instructions

1. Complete Section I. Enter your name as it appears on your Licensure Application (Form 1). Be sure to sign and date item 6.
2. Send this form to each licensing authority in another country where you have been licensed and have practiced within the past five years. Request that they complete Section II below and return this form **directly** to the Office of the Professions at the address at the end of this form. Be sure to include any fee(s) required. If additional forms are needed, please photocopy this form. Verifications must be in English or otherwise submitted with an official translation. **We will not accept this form if submitted by the applicant or a third party.**

Section I: Applicant Information

1 **Social Security Number** ☐☐☐-☐☐-☐☐☐☐

(Leave this blank if you have no U.S. Social Security Number)

2 **Birth Date** ☐☐ ☐☐ ☐☐

Month Day Year

3 **Print Full Name Exactly 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 name of jurisdiction and country ____________________

Name under which you are licensed in that jurisdiction and country ____________________

Date of Licensure _______ / _______ / _______ License Number ____________________

mo. day yr.

6

I request and give my permission to the licensing authority listed in item 5 above to complete the information on this form and mail it to the New York State Education Department and to release any other information required by the State Education Department in connection with my application for licensure.

Applicant's signature: ____________________ Date: _______ / _______ / _______

mo. day yr.

Rev. 6/15

Section II: Verification of Licensure

Instructions to Licensing Authority: Please complete this section and return the entire form ***directly*** to the Office of the Professions at the address shown below. **This form will not be accepted if returned by the applicant or third party.**

1 Name of applicant: ____

(See item 3 on page 1)

License number: ________________________ Date issued: _______ / _______ / _______
mo. day yr.

Expiration of most recent registration: _______ / _______ / _______
mo. day yr.

2 a. Has the applicant named in Section I been subject to any disciplinary action? ❑ **YES** ❑ **NO**

b. Are any charges pending against this individual? ❑ **YES** ❑ **NO**

If the answer to either of these questions is "Yes," please attach relevant information.

Certification

I certify that the information shown above is true and correct, according to the records of this office.

Signature: ____ Date: _______ / _______ / _______

Print Name: ____

Title: ____

Name of Jurisdiction: ____

Address: ____

____

(LICENSING AUTHORITY SEAL)

Telephone: ______________________________

Fax: ______________________________

E-mail Address: ____

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