STATE EDUCATION DEPARTMENT Unofficial Sample Unofficial

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Office of Teaching Initiatives, 89 Washington Ave., Albany, NY 12234 Print name exactly as it currently appears on New York State Education Last Name: First Name: Middle Name/Initial: Print your address: Care of: Street: City: State: Zip Code: Date of Birth Month Day: Yes Last 4 of the Social Security Number: Trainee's Signature: Date:	Trainee must complete ALL items in Part A. Return to provider for completic "Certification by Approved Provider". An incomplete form will not be processed. The provider will return the Certification form, with Part B completed, to the trainee's responsibility to submit the original copy of this Certification form to State Education Department at the appropriate time. It should be submitted relevant forms when the trainee applies for certification. 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Return to provider for completion of Part B, "Certification by Approved Provider". An incomplete form will not be processed. The provider will return the Certification form, with Part B completed, to the trainee. It is the trainee's responsibility to submit the original copy of this Certification form to the New York State Education Department at the appropriate time. It should be submitted along with othe relevant forms when the trainee applies for certification. Mail to: NYS Education Department Office of Teaching Initiatives, 89 Washington Ave., Albany, NY 12234 Print name exactly as it currently appears on New York State Education Department record Last Name: First Name: Middle Name/Initial: Print your address: Care of: Street: City: State: Zip Code: Date of Birth Month Day: Year: Last 4 of the Social Security Number: Trainee's Signature: Date:

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This section must be completed by the provider

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