Credential Verification Service for New York State

2008 Authorization for Academic Records (Transcripts)

CGFNS International • 3600 Market Street, Suite 400, Philadelphia, Pennsylvania 19104-2651 U.S.A. • Phone: 215.222.8454 • Web: www.cgfns.org

Dear Registration Authority: My CGFNS/ICHP ID#: (if known) _____ Order #: (if known) _____

I have applied to the New York State Education Department for licensure as a REGISTERED NURSE .
That department has authorized the Commission on Graduates of Foreign Nursing Schools (CGFNS) to obtain official transcripts of my academic record. Please send an official transcript of my academic record directly to CGFNS. My information appears below.

I received my education from: _____ / _____
(English Spelling) (Native Language)

The name I used when I attended your school was: _____ / _____
(English Spelling) (Native Language)

My current name is: (if different than above) _____ / _____
(English Spelling) (Native Language)

Date of Birth: Month _____ Day _____ Year _____ Dates of Attendance: _____ to _____
Month/Day/Year Month/Day/Year

I hereby authorize CGFNS to obtain any and all documents and/or information regarding my academic records. I also authorize CGFNS to disclose certain information about me to the New York State Education Department, to any person or organization that I designate in writing, and any other recipient that CGFNS believes has a legitimate interest in receiving it (such as government agencies or potential employers). CGFNS may disclose information and documents regarding my academic records, the status of any reports, evaluations or verifications prepared by CGFNS, any other information obtained by CGFNS, and the results and reasons for any adverse action that CGFNS may take against me.

Signature:_____ Date: _____

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Signature:_____ Date: _____

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2008 Authorization for Validation of Registration/License

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Dear Registration Authority: My CGFNS/ICHP ID#: (if known) _____ Order #: (if known) _____

I have applied to the New York State Education Department for licensure as a REGISTERED NURSE .
That department has authorized the Commission on Graduates of Foreign Nursing Schools (CGFNS) to obtain official validation of my registration/license. Please send an official validation of my registration/license directly to CGFNS. My information appears below.

Name of Registration Authority: MINISTRY OF HEALTH AND WELFARE / JUNGANGDONG 1, GWACHEON, GYEONGGIDO, KOREA(SOUTH)

The registration/license was issued under the name of: _____ / _____
(English Spelling) (Native Language)

My current name is: (if different than above) _____ / _____
(English Spelling) (Native Language)

Registration/license number: _____ Date of Birth: Month _____ Day _____ Year _____

I received my education from: _____
(School Name)

I hereby authorize CGFNS to obtain any and all documents and/or information regarding my registration/license. I also authorize CGFNS to disclose certain information about me to the New York State Education Department, to any person or organization that I designate in writing, and any other recipient that CGFNS believes has a legitimate interest in receiving it (such as government agencies or potential employers). CGFNS may disclose the information and documents pertaining to my registration/license, the status of any reports, evaluations or verifications prepared by CGFNS, any other information obtained by CGFNS, and the results and reasons for any adverse action that CGFNS may take against me.

Signature: _____ Date: _____

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Signature: _____ Date: _____

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15 Attestation:

Please Note: Each applicant must sign his/her full name in English on the applicant's signature line.

I certify that all information which CGFNS has received as part of this application or in the past, from me or from a third party on my behalf, is true and complete. I also certify that all documents which have been submitted to CGFNS for any purpose have not been falsified, altered or tampered with by any person.

I understand that CGFNS and others will rely on this application and on the documents and information submitted, and that if any of it is falsified, altered or tampered with, or if I misrepresent a copy as an original, CGFNS may take such disciplinary action against me as it deems appropriate, **including barring me from participation in any CGFNS/ICHP programs or to otherwise discipline me as appropriate.** The consequences could adversely affect my professional license, immigration status, employment and other matters, from which I release CGFNS from all liability.

I authorize CGFNS to disclose the information and documents in this application, the status of my CGFNS Certificate, any reports or evaluations prepared by CGFNS, any other information obtained by CGFNS and the results and reasons for any adverse action taken against me by CGFNS, to any person or organization I designate in writing or to any other recipient which CGFNS may determine has a legitimate interest in receiving the same, such as government agencies or potential employers.

You must sign and date this application in order for it to be processed.

Print Name _____ Date of Birth _____ (Month / Day / Year) Order No. or CGFNS ID No. _____

Signature of Applicant (Do Not Print) _____ (Sign Entire Name) Date _____ (Month / Day / Year)

Signature of Notary _____ (Sign Entire Name) Date _____ (Month / Day / Year)

Print Name of Notary _____

Official seal/stamp must cover signatures

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Payment by Credit Card Form

Please type or print. Complete all information requested on both sides of this form.

Credit Card Type (check one): **CGFNS does not accept American Express**

☐ Visa ☐ MasterCard ☐ Discover/Novus

Credit Card #: | | | | | | | | | | | | | | | | |

Expiration Date: _____ ***CVV2 Number** _____
(See explanation on other side.)

Total Charges (see "Fee Schedule"): **U.S. $** _____

Name of Cardholder (as it appears on card):

_____

Cardholder Address: (For processing credit card payments only. All materials requested will be sent to the applicant address provided on the appropriate forms.)

_____

_____

_____

Cardholder Signature (authorization for payment):
I hereby authorize a charge to my credit card for the total of all services requested on the attached **Credential Verification Service for New York State Application Form**, including any fee adjustments in effect as of the date the order is received.

X _____
Signature of Authorized Cardholder

22 CHILD ABUSE IDENTIFICATION AND REPORTING COURSEWORK REQUIREMENT – RN Applicants Only (check one):

- ☐ I graduated from a NYS registered nursing program after September 1, 1990 and completed the coursework during my studies.
- ☐ I completed the child abuse coursework and have enclosed a certificate of completion from an approved provider.
- ☐ I completed the child abuse coursework online and the approved provider will report that to you electronically.
- ☑ I am filing for an exemption to the requirement and have enclosed the Certification of Exemption (Form 1CE).

23 EDUCATION PROGRAM REVIEW

I give permission to the New York State Education Department to release my examination results to my professional school for the confidential purposes of program review and institution research and planning. I may rescind this authority at any time by notifying the Division of Professional Licensing Services in writing.

☑ Yes ☐ No Please initial: _____

24 PHOTOGRAPH REQUIREMENT:

DO NOT STAPLE

ATTACH SECURELY IN THIS SPACE A 2" X 2" PASSPORT STYLE PHOTOGRAPH TAKEN WITHIN THE PAST YEAR

Date of photo: _____

25 GENDER AND ETHNICITY: (This item is optional.)

Information on gender and ethnicity is sought solely to allow the New York State Education Department to collect and analyze data concerning diversity in the licensed professions. The ethnic and gender data you provide will be used only for statistical, research, and program evaluation purposes. It will not be released to the public. This information has absolutely no bearing on your qualification for licensure.

GENDER: ☐ Male ☑ Female

ETHNICITY: ☐ White (not Hispanic) ☐ Black (not Hispanic) ☑ Asian ☐ Hispanic ☐ Native American

26 AFFIDAVIT WITH ACKNOWLEDGMENT (Notarization required.)

Applicant

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.

Applicant's signature _____ Date _____ / _____ / _____
Month Day Year

Notary

State of _____ County of _____

On the _____ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public's signature _____

Notary ID number _____

Notary Stamp

Expiration date _____ / _____ / _____
Month Day Year

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, PO Box 22063, Albany, NY 12201. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.

Form 1CE

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

CERTIFICATION OF EXEMPTION

IDENTIFICATION AND REPORTING CHILD ABUSE and MALTREATMENT TRAINING

Applicants for licensure and licensees applying for re-registration as **physicians, chiropractors, dentists, registered nurses, podiatrists, optometrists, psychologists, dental hygienists, licensed master social workers, licensed clinical social workers, creative arts therapists, marriage and family therapists, mental health counselors, and psychoanalysts** must complete two hours of Department approved coursework or training in the identification and reporting of child abuse and maltreatment. A limited exemption from this requirement is available if the nature of the applicant's/licensee's practice excludes contact with children. Any licensee who asks for an exemption must notify the Department in writing, within 30 days, when the nature of the practice changes and an exemption is no longer valid.

APPLICANT INSTRUCTIONS

1. If you are certain that you qualify for an exemption, complete items 1-6 by printing clearly in ink in the spaces provided. Be sure to sign and date Item 7
2. Send the completed form to the address shown above to the attention of the unit for your profession (for example: Attention Medicine Unit). See item 6 for listing.

Properly completed forms will be accepted. You will only receive notice from the Department if a request is insufficient to grant an exemption. Please retain a photocopy of this Certification of Exemption.

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 Or Registration**

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 **N.Y.S. License Number**
(If applicable)

6 **Profession** *(check one)*

- ☐ Medicine
- ☐ Chiropractic
- ☐ Dentistry
- ☐ Dental Hygiene
- ☑ Registered Nurse
- ☐ Podiatry
- ☐ Optometry
- ☐ Psychology
- ☐ Licensed Master Social Worker
- ☐ Licensed Clinical Social Worker
- ☐ Creative Arts Therapist
- ☐ Marriage and Family Therapist
- ☐ Mental Health Counselor
- ☐ Psychoanalyst

7 **ATTESTATION**

59.12 (b) The department may exempt an applicant or licensee from the coursework or training requirement of subdivision (a) of this section upon receipt of a written application for such exemption establishing that there would be no need to complete the coursework or training because the nature of the applicant's/licensee's practice excludes contact with children. It is the professional responsibility of the licensee who holds an exemption to notify the department in writing, within 30 days, when the nature of the practice changes to the extent that the basis for exemption ceases to exist.

I, the undersigned, have read regulation 59.12(b) above and the explanation on this form. I understand the terms and conditions contained therein, and hereby declare that the nature of my practice is such that I do not treat or otherwise have professional contact either with children under the age of 18 years or persons 18 years of age and older with a handicapping condition who reside in a residential care school or facility. Therefore, I claim an exemption from the required training in child abuse and maltreatment identification and reporting pursuant to Section 59.12, Regulations of the Commissioner.

I also understand that should the nature of my practice change to the extent that the basis for the exemption ceases to exist, I am obligated to notify the department in writing and complete the required training within 30 days.

I further understand that a false statement on this document may be cause for denial or loss of licensure and may result in criminal prosecution.

_____ _____
Applicant signature *Date*