



New York State
 DEPARTMENT OF STATE
 Division of Licensing Services
 P.O. Box 22001
 Albany, NY 12201-2001

Customer Service: (518) 474-4429
 www.dos.ny.gov

Health Certification Form

To the Health Care Professional:

This form should be used for patients who need to be examined by a physician, physician's assistant or a nurse practitioner* to apply for a license in the appearance enhancement or barber industry. Please complete the below portion of this form and sign and date the form.

To the Appearance Enhancement and/or Barber Applicant:

You need to have a physical examination to apply for a license in Cosmetology, Esthetics, Nail Specialty, Natural Hair Styling, Waxing and Barbering. Your physician, physician's assistant or a nurse practitioner* must complete, sign and date this Health Certification. You must submit your online license application within 30 days from the date of this examination.

***Please note:** In accordance with statutory provisions, a nurse practitioner's signature is not acceptable if you are applying for a Barber license.

Instructions:

Please utilize the information contained on the below certification when applying for your license online. You will be required to enter information from this form into the health certification fields within the system.

Please note: This completed Health Certification Form is subject to audit by an investigator to ensure compliance with this requirement. Evidence of this form must be maintained on your work premises for 3 years for audit purposes.

Health Certification:

I am a duly licensed Physician , duly licensed Physicians Assistant , or duly licensed Nurse Practitioner , and hereby state

that in the course of a routine examination of _____, on
(Applicant's Name)

_____. I found no clinical evidence of the presence of infectious or
(Date of Physical Examination)

communicable disease which would pose a significant risk or direct threat to the health or safety of members of the public in the conduct of the applicant's occupation.

Print Name of Physician: _____ Date: _____

Address of Practice: _____

Physician's Signature: _____ Title: _____