Return to: eMedNY
PO Box 4610
Rensselaer NY 12144-4610

EMPLOYMENT CERTIFICATION FOR CERTIFIED EDUCATOR

This Form Must Be Completed and Signed by Each Employer

1. Employer Name: _____

2. Employer License Number (if practitioner): _____

3. Employer National Provider Identifier (NPI): _____

   Employer Medicaid Provider #_____

4. Employer Telephone Number: _____

5. Employer Current Service Address: _____

   _____

   _____

6. Will the Certified Educator practice at the same service location(s) at which you practice?

   ☐ Yes ☐ No

   If no is checked, list locations where the Certified Educator will practice.

   _____

   _____

   _____

CERTIFICATION STATEMENT

I swear that the information that I have provided is true and accurate to the best of my knowledge. I agree to notify, in writing, the Department of Health (DOH), Division of Provider Relations and Utilization Management if for any reason the National Certification of this educator is no longer active.

Employing Physician Signature: _____

Print Name _____ Date _____