VERIFICATION OF STATE LICENSURE

State Form 7143 (R2 / 10-91)

*** PRIVACY NOTICE ***

This State agency is requesting disclosure of your Social Security number, under IC 4-1-8-1. Disclosure is mandatory, and this form will not be processed without it.

HEALTH PROFESSIONS BUREAU
Indiana Government Center South
402 W. Washington St., Rm 041
Indianapolis, Indiana 46204
Telephone: (317) 232-2960

INSTRUCTIONS: Type and complete the top section. Make copies to send to each state that you hold or have held a license. Have the state(s) send this directly to our office.

Name *(Last, first, middle, maiden)*		Health Profession License Held	Social Security Number *
Address *(Number, street, or / rural route)*		City	State / ZIP code
License number	Date of Issuance *(month, day, year)*	Date of Birth *(month, day, year)*	

I hereby authorize the State of , to furnish the Health Profession Bureau of Indiana with the information below.

Signature

* Required pursuant to IC 4-1-8-1

DO NOT WRITE BELOW THIS LINE

License number	Date of Issuance *(month, day, year)*	Licensed by ☐ Exam ☐ Endorsement ☐ Other	
Type of Examination	Date of Administration *(month, day, year)*		Please Affix Board Seal

Attach subjects, scores, date of examination and average.

License is current and in good standing ☐ Yes ☐ No	License is or has been invalid ☐ Yes ☐ No	Any derogatory information ? ☐ Yes ☐ No

If license has been encumbered in any way, please provide certified copies of all related documents.

FORM COMPLETED BY:

Name	Title	
Signature	State Board	Date *(month, day, year)*

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