# GOVERNMENT OF THE DISTRICT OF COLUMBIA
## DEPARTMENT OF HEALTH
### HEALTH REGULATION AND LICENSING ADMINISTRATION

**VERIFICATION OF LICENSURE STATUS**

Verification of the status of a DC health care practitioner's license can be obtained by completing the form below and attaching a payment of **$34.00 per license per recipient**. The check must be made payable to the DC Treasurer and mailed together with the form to:

**DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH**
**HEALTH REGULATION AND LICENSING ADMINISTRATION**
**VERIFICATIONS**
**PO BOX 37804**
**WASHINGTON, DC 20013**

If the intended recipient has an electronic verification system, please provide the email information for submission.

The processing and mailing of verification request **may take up to 30 business days**. Please be advised that incomplete verification requests will greatly increase the time it takes to complete a request. If the recipient jurisdiction or institution only requires a standard letter, please make sure to include the licensee's name, date of birth, and license number in your request.

**VERIFICATIONS FROM THE BOARD OF NURSING**
Licensees may contact the RN/LPN licensure verification access system at www.nursys.com

**VERIFICATIONS FROM THE BOARD OF MEDICINE**
Postgraduate Physician Trainees (PPTs) are not licenses therefore will **not be verified as such to any external body**. Please contact the program where the licensee was a trainee. PPT requests will be mailed back to physicians and refunded.

Each license held under one licensee that requires verification will cost $34.00 per recipient.

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# REQUEST OF VERIFICATION OF LICENSURE STATUS FORM

**(Please print legibly)**

NAME OF THE BOARD YOU ARE REQUESTING THE VERIFICATION FROM:

_____

**Licensee Information:**

HOW WERE YOU LICENSED: ENDORSEMENT ____ EXAMINATION ____

LICENSE NUMBER (if known):_____ DATES OF LICENSURE (if known): _____

SOCIAL SECURITY #: _____

YOUR NAME (if you used another name when you were licensed indicate that name):

_____
Last Name First Name Middle Name

YOUR ADDRESS:_____

City: _____ State: _____ Zip Code:_____

YOUR TELEPHONE NUMBER: _____ Email Address: _____

I hereby authorize the DC Department of Health to release any information, favorable or otherwise against my license to the state licensing board/entity or person listed below.

Signature: _____ Date: _____

**Mailing Information:**

IF YOU HAVE A FORM FROM A JURISDICTION OR INSTITUTION ATTACH THE FORM, THE PAYMENT AND MAIL IT TO: PO BOX 37804, WASHINGTON, DC 20013.

**NAME AND ADDRESS OF WHERE YOU WANT THE VERIFICATION SENT:**

State Board Name: _____

Mailing Address: _____

City:_____ State:_____ Zip Code:_____