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

## Verification of Licensure Status

A verification of licensure status for a health care practitioner or health facility can be obtained two ways and the fee is $34.00 payable to the DC Treasurer. **The processing and mailing of verification requests may take 20 business days** and you will be notified, by email, when your verification has been mailed.

A) If you have a form from the jurisdiction or institution that must be completed by the DC Department of Health, complete the form below, attach the verification request form supplied by the other state board, the required fee and mail it to our office. If the jurisdiction or institution has an electronic verification system, please provide the email information for submission.

B) If you want a letter to be sent to a particular entity, complete the form below, attach the required fee, and mail it to our office.

**MAILING ADDRESS FOR VERIFICATION REQUESTS**
District of Columbia Department of Health
Health Regulation and Licensing Administration
899 North Capitol Street, N.E. First Floor
Washington, DC 20002

**NURSES ONLY** may contact the RN/LPN licensure verification access system at www.nursys.com .

**Contact Information**
District of Columbia Department of Health
Health Regulation and Licensure Administration
**Phone number:** 877-672-2174
**Office hours:** Monday – Friday 8:30am – 4:30pm
**Location:** 899 North Capitol Street, N.E. First Floor Washington, DC 20002

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

# 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 INSTITUION ATTACH THE FORM, THE PAYMENT AND MAIL IT TO US.

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

State Board Name: _____

Mailing Address: _____

City:_____ State:_____ Zip Code:_____