

PHYSICIAN VERIFICATION OF LICENSURE

(Copy this form for multiple licenses)

This form is for verification of all medical licenses from every U.S./Canadian board issuing any type of license including training, locum tenens, and temporary permit even if license is not current. Each Board completing the form must email, mail or fax directly to the **Minnesota Board of Medical Practice**. Any fees are applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

State Medical Board verifications and verifications through VeriDoc are also accepted in lieu of this form. Log on to www.veridoc.org and follow the onscreen instructions.

Print Name _____ Last 4 digits of SSN _____
Signature _____ Date _____
License Number _____ Birthdate _____

THE STATE BOARD COMPLETES THE FOLLOWING INFORMATION:

IT IS HEREBY CERTIFIED THAT: (Name of Physician) _____

DATE OF BIRTH: (Month, Day, Year) _____

WAS ISSUED LICENSE NUMBER: _____

BY: (state) _____ **ON:** (Month, Day, Year) _____

EXPIRATION DATE: (Month, Day, Year) _____

ISSUED ON THE BASIS OF: (Exam) _____

DISCIPLINARY ACTION EVERY INITIATED, PENDING, OR INVOKED*: (Yes/No) _____

EVER VOLUNTARILY RELINQUISHED MEDICAL LICENSE*: (Yes/No) _____

ANY DEROGATORY INFORMATION WHICH YOU CAN RELEASE*: (Yes/No) _____

Print Name _____

Signature _____

Title _____

Date _____

Phone _____

*If yes, please attach letter of explanation on letterhead.

**If there is no seal, attach letter of explanation on letterhead.

NOTE TO APPLICANT: Most states charge a fee for this service.