

**ACUPUNCTURIST
Verification of Licensure/Registration/Certification**

This form is for verification of all acupuncturist and other healthcare professional licenses or registrations from every jurisdiction issuing any type of license, registration, or certification including training, and temporary permit even if license is not current. **Each Board completing this form must email or mail 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.

Print Name _____ SS# _____

Signature _____ Date _____

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The jurisdiction completes the following information:

It is hereby certified that: _____
(Name of Applicant)

Date of birth: _____
(Month / Day / Year)

Was issued license/registration number: _____

By: _____ On: _____
(State) (Month / Day / Year)

Expiration date is: _____
(Month / Day / Year)

Issued on the basis of: _____

Disciplinary action ever initiated, pending, or invoked? Yes* _____ No _____

Ever voluntarily relinquished license? Yes* _____ No _____

State Print name: _____

Seal** Signature: _____

Title: _____

Date: _____

*If yes, please attach letter of explanation.

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