

Medical Board License Verification Request Form

This form is used to request verification of a healthcare professional's medical license for credentialing or licensing purposes.

1. Professional Information

Full Name:

Date of Birth:

License Number:

State/Country of Issuance:

Date of Issuance:

Expiration Date:

2. Contact Information of Requesting Party

Organization Name:

Contact Person:

Email:

Phone Number:

3. Verification Request Details

Purpose of Verification:

e.g., Credentialing, Employment, License renewal

Preferred Delivery Method:

e.g., Email, Mail, Fax

4. Authorization and Signature

I hereby authorize the release of my licensure information to the above-listed organization.

Signature:

Date:

Submit Request

Note: This is a sample template for general informational purposes. Please consult your respective medical board or credentialing authority for their specific requirements and processes.