

**Commonwealth of Massachusetts Board of Registration in Medicine
200 Harvard Mill Square, Suite #330 Wakefield, MA 01880 (781) 876-8210
www.massmedboard.org**

STATE LICENSE VERIFICATION

Applicant's Instructions: Complete the waiver for release of information and forward this form to every state board where you are currently licensed or were ever licensed in the past. Contact the individual state board(s) for information on verification processing fees before you mail this form.

Applicant's Waiver for Release of Information:

I am applying for licensure in the Commonwealth of Massachusetts and the Board of Registration in Medicine requires that this form be completed by each state where I hold or have ever held licensure. I hereby authorize the release of any information in your files, favorable or otherwise.

Signature of physician: _____ Date: ____/____/____

Print or type name: _____

License number: _____ Status of license: Active Inactive Other _____

TO BE COMPLETED BY STATE BOARD

1. Name of medical school of graduation: _____

2. Date of graduation: ____/____/____ License number: _____ Date of issue: ____/____/____

3. Basis for licensure:

_____ Name(s) of medical licensing examinations(s).

4. Expiration date of license: ____/____/____

5. Status of license: (check one) good standing revoked suspended

6. If revoked or suspended, please explain: _____

	YES	NO
7. Has the licensee ever been on probation?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the licensee ever been requested to appear before the board?	<input type="checkbox"/>	<input type="checkbox"/>

If "yes," please explain: _____

Other derogatory information: _____

Remarks: _____

Signed: _____

BOARD SEAL

Print Name: _____

Title: _____

State Board: _____ Date: ____/____/____

PLEASE RETURN THE STATE LICENSE VERIFICATION TO THE APPLICANT IN A SEALED ENVELOPE WITH THE BOARD SEAL OR THE SIGNATURE OF THE PERSON COMPLETING THIS FORM ON THE BACK OF THE ENVELOPE.