**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 ______________

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**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 examination(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? □ □

8. Has the licensee ever been requested to appear before the board? □ □

   If “yes,” please explain: __________________________

Other derogatory information: __________________________

Remarks: __________________________

Signed: __________________________________________

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.

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