DC | HEALTH
Health Regulation & Licensing Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Veterinarian License Application
Request for Verification of Licensure

Name of Applicant _____

Social Security Number_____

License Number _____

Dear Sir/Madam:

The applicant whose name appears above has applied to the Board of Veterinary Medicine of the District of Columbia for a license to practice veterinary medicine. The applicant claims to have held a license to practice veterinary medicine in your state and claims the above license number. This request is being forwarded to you to verify that the applicant is currently licensed and in good standing to practice veterinary medicine in your state.

Each applicant for a veterinarian license by endorsement in the District of Columbia is required by statute to submit proof that the jurisdiction where the applicant is licensed will currently grant licenses to licensees from the District of Columbia without further examination. If your licensing board requires a reciprocity candidate from the District of Columbia to take any type of examination (written, oral, or practical) or any type of interview, your requirements should be specified in the "Remarks" section on Page 2 of this certification form.

Please complete and return this form to:
HRLA1-Board of Veterinary Medicine
P.O. Box 37801
Washington, D.C. 20013

Your prompt attention to this request will expedite consideration of the candidate's application for licensure.

Thank you in advance for your cooperation.

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VERIFICATION OF LICENSURE STATUS

Verification of the status of a DC health care practitioner's license can be obtained by completing the form below and attaching a payment of **$34.00 per license per recipient**. The check must be made payable to the DC Treasurer and mailed together with the form to:

DISTRICT OF COLUMBIA DC HEALTH
HEALTH REGULATION AND LICENSING
ADMINISTRATION VERIFICATIONS
PO BOX 37804
WASHINGTON, DC 20013

If the intended recipient has an electronic verification system, please provide the email information for submission.

The processing and mailing of verification request **may take up to 30 business days**. Please be advised that incomplete verification requests will greatly increase the time it takes to complete a request. If the recipient jurisdiction or institution only requires a standard letter, please make sure to include the licensee's name, date of birth, and license number in your request.

VERIFICATIONS FROM THE BOARD OF NURSING
Licensees may contact the RN/LPN licensure verification access system at www.nursys.com

VERIFICATIONS FROM THE BOARD OF MEDICINE
Postgraduate Physician Trainees (PPTs) are not licenses therefore will **not be verified as such to any external body**. Please contact the program where the licensee was a trainee. PPT requests will be mailed back to physicians and refunded.

Each license held under one licensee that requires verification will cost $34.00 per recipient.

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REQUEST OF VERIFICATION OF LICENSURE STATUS FORM

(Please print legibly)

NAME OF THE BOARD YOU ARE REQUESTING THE VERIFICATION FROM:

_____

Licensee Information:

HOW WERE YOU LICENSED: ENDORSEMENT ____ EXAMINATION ____

LICENSE NUMBER (if known):_____ DATES OF LICENSURE (if known): _____

SOCIAL SECURITY #: _____

YOUR NAME (if you used another name when you were licensed indicate that name):

_____

Last Name First Name Middle Name

YOUR ADDRESS:_____

City: _____ State: _____ Zip Code:_____

YOUR TELEPHONE NUMBER: _____ Email Address: _____

I hereby authorize the DC Department of Health to release any information, favorable or otherwise against my license to the state licensing board/entity or person listed below.

Signature: _____ Date: _____

Mailing Information:

IF YOU HAVE A FORM FROM A JURISDICTION OR INSTITUTION ATTACH THE FORM, THE PAYMENT AND MAIL IT TO: PO BOX 37804, WASHINGTON, DC 20013.

NAME AND ADDRESS OF WHERE YOU WANT THE VERIFICATION SENT:

State Board Name: _____

Mailing Address: _____

City:_____ State:_____ Zip Code:_____