

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION AND LICENSING ADMINISTRATION

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 DEPARTMENT OF HEALTH HEALTH
REGULATION AND LICENSING ADMINISTRATION
VERIFICATIONS
2201 Shannon PI SE, 1st Floor Washington, DC 20020

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.

BOARD OF NURSING VERIFICATIONS

RN and **LPN** licensure verifications:

To submit a verification of your DC license **to a state board of nursing within the U.S.:** please submit your request via Nursys at www.nursys.com (all U.S. boards of nursing only accept RN and LPN verifications via Nursys).

To submit a verification of your DC **license to an entity that is NOT a state board of nursing within the U.S.**, please submit this form and your payment of \$34 to the DC Department of Health at the address provided.

APRN licensure verifications:

To submit a verification of your DC APRN license to any entity (including all U.S. boards of nursing), please submit this form and your payment of \$34 to the DC Department of Health at the address provided.

BOARD OF MEDICINE VERIFICATIONS

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: _____

NAME AND ADDRESS OF WHERE YOU WANT THE VERIFICATION SENT:

State Board Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____