DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

Government of the District of Columbia

DC Health

SSN AFFIDAVIT

I, _____, do hereby state under penalty of perjury the following:
(First Name, Last Name)

As of the date that my signature appears on this affidavit, I have not been issued a United States Social Security Number (SSN). I have/will undertake efforts to obtain a SSN and will provide the SSN to the Board within fifteen (15) days of receiving it, and no later than 120 days.

I understand that if I obtain a SSN and fail to timely submit the SSN to the Board, the Board may take appropriate action, which may affect my continued ability to practice within the District of Columbia. In addition, I understand that if I do not obtain a SSN within 120 days I could jeopardize my continued licensure within the District of Columbia.

_____ _____
(Date) *(Signature)*

Sworn and subscribed to before me this _____ day of _____, _____ (Year)

_____
(Notary Public)