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
899 North Capitol Street, NE, 1st Floor
WASHINGTON, DC 20002

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.

Last Update: 8/24/2021
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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: 899 North Capitol Street, NE, 1st Floor, Washington, DC 20002.

NAME AND ADDRESS OF WHERE YOU WANT THE VERIFICATION SENT:

State Board Name: __________________________________________________________

Mailing Address: __________________________________________________________

City:_________________________  State:___________________  Zip Code: __________

Last Update: 8/24/2021