



# 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 Place, 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 <u>www.nursys.com</u> (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.



## GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH

HEALTH REGULATION AND LICENSING ADMINISTRATION

NAME OF THE BOARD YOU ARE REQUESTING THE VERIFICATION FROM:

Licensee Information:		
HOW WERE YOU LICENSED	ENDORSEMENTE	XAMINATION
LICENSE NUMBER (if knowr	n):DATES O	PF LICENSURE (if known):
SOCIAL SECURITY #:		
YOUR NAME (if you used a	nother name when you were	e licensed indicate that name):
Last Name	First Name	Middle Name
YOUR ADDRESS:		
City:	State:	Zip Coo
YOUR TELEPHONE NUMBER	3:	Email Address:
-	-	ease any information, favorable rd/entity or person listed below
Signature:		Date:
Mailing Information:		
		TUTION ATTACH THE FORM, TH <mark>st Floor, Washington, DC 2</mark> 0020
NAME AND ADDRESS OF V	VHERE YOU WANT THE VERI	IFICATION SENT:
State Board Name:		
Mailing Address:		
City:	State:_	Zip C