



MD

TO: State Medical Licensing

NAME OF LICENSING AGENCY _____

ADDRESS _____

RE: Verification of License/Registration as a Physician

I am applying for a license to practice medicine as a physician and surgeon in the state of Washington and before my application can be reviewed, a verification of my licensure status in your state is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, **directly** to the address shown below. **Please note, all questions must be answered.**

APPLICANT (PRINT OR TYPE) _____ BIRTHDATE _____

SIGNATURE OF APPLICANT _____

This is verify that _____ was issued license
number _____ on _____ .

1. Date license, registration, or certification expires _____

2. Have any complaints been lodged against the license? Yes No

3. Is there currently any investigation in process regarding the license? Yes No

4. Has any disciplinary activity taken place regarding this license? Yes No

If yes, please provide any information or documentation which may be released; i.e., charges and final disposition.

Return to:

Medical Quality Assurance Commission
P O Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

Signature _____

Title _____

Hospital _____

PLEASE TYPE OR PRINT

Address _____

Date _____

Telephone _____

(SEAL)