Licensure Verification for Medical Programs Applicants

PRIVACY ACT STATEMENT

AUTHORITY AND PURPOSE: 5 U.S.C. 301, Departmental Regulations; and E.O. 9397 (SSN). Provided information is used to assist officials and employees of the Navy in the management, supervision and administration of Navy personnel (officer and enlisted) and the operations of related personnel affairs and functions.
ROUTINE USES: Information will be utilized by Department of the Navy officials in verifying qualifications and suitability for future assignments.
DISCLOSURE: Voluntary. However, failure to provide the requested information may result in an administrative assignment to future duty without your preferences.

I, _____ hereby certify that telephone verification was made to the
(Recruiter's Name and Rank)

_____ State Board of _____
(State Licensure Board/Representative/ Phone Number (Medical Profession)

_____ with _____ who states that license
(Date) (Applicant's Full Name, First, Middle and Last)

_____ in _____ is still valid and in good standing.
(License Number) (Medical Specialty)

Initial Issuance: _____

Current Expiration: _____

Current Status: _____

Disciplinary Proceedings: _____

Malpractice Pending: _____

Recruiter's Typed Name: _____

Recruiters Signature: _____

Date: _____