

VERIFICATION OF MEDICALLY RELATED LICENCE

TO APPLICANT: Complete this section and submit the form to the jurisdiction from which you are requesting verification of licensure, certification, or registration
THIS FORM WILL NOT BE ACCEPTED IF RETURNED BY THE APPLICANT.

Name You Were Licensed Under _____ Current Name, if Different _____
Social Security/Insurance Number _____ Date of Birth _____
Mailing Address _____
Type of Licence Granted _____ Licence Number _____ Date Licence Granted _____

TO JURISDICTION FROM WHICH VERIFICATION IS BEING REQUESTED: Please verify below that the above-named person has been issued licensure, certification, or registration in your state/province or jurisdiction, and advise if the licence has ever been suspended or revoked, and if there has ever been any complaints, disciplinary action taken against the holder of the licence. **You may submit your standard certificate provided it contains the information requested below. Please return this form directly to the College at the address at the top of this form.**

Type of Licence _____ Licence Number _____
Date Issued _____ Expiration Date _____

- (a) HAS THE APPLICANT EVER BEEN THE SUBJECT OF A REVIEW OF HIS/HER CONDUCT, COMPETENCE, OR CAPACITY OR FITNESS TO PRACTISE, WHETHER ARISING FROM A COMPLAINT OR OTHERWISE?
No Yes Give Particulars
- (b) IS THE APPLICANT CURRENTLY THE SUBJECT OF AN INVESTIGATION OR OTHER PROCEEDING IN RELATION TO HIS/HER CONDUCT, COMPETENCE, OR CAPACITY OR FITNESS TO PRACTISE?
No Yes Give Particulars
- (c) HAS THE APPLICANT EVER BEEN THE SUBJECT OF A FINDING OF PROFESSIONAL MISCONDUCT, CONDUCT UNBECOMING, INCOMPETENCE, OR AN INCAPACITY OR LACK OF FITNESS TO PRACTISE?
No Yes Give Particulars
- (d) HAS THE APPLICANT EVER BEEN DENIED AN APPLICATION FOR LICENSURE, REGISTRATION, PERMIT OR ANY OTHER AUTHORIZATION TO PRACTISE?
No Yes Give Particulars
- (e) HAS THE APPLICANT EVER BEEN THE SUBJECT OF A SUSPENSION OF, RESTRICTION ON, OR REVOCATION OF LICENSURE, REGISTRATION, PERMIT OR ANY OTHER AUTHORITY TO PRACTISE?
No Yes Give Particulars

Signature _____ (Affix agency seal here) _____ Name of Licensing Agency _____
Your Title _____ Address _____
Date _____ Phone Number _____ City/State or Province/Zip or Postal Code _____