

NORTH DAKOTA BOARD OF PODIATRIC MEDICINE

911 ELM AVE. DICKINSON ND 58601

701-483-9165

Request for license verification.

Please request each licensing agency where you hold license (states) to complete this form and return to the address above.

NAME OF APPLICANT: _____

LICENSE #: _____ **SSN#:** _____

ADDRESS: _____

STATE LICENSED: _____ **ADDRESS:** _____

DATE ISSUED: _____ **LICENSE TYPE:** TEMPORARY _____ PERMANENT _____

IS THIS LICENSE CURRENTLY VALID? Yes _____ No _____ Exp. Date: _____

REASON FOR TERMINATION: _____

DISCIPLINARY ACTION TAKEN? PLEASE EXPLAIN: _____

ORIGINAL LICENSE WAS ISSUED ON THE BASIS OF:

EXAMINATION: _____ **RECEIPROCITY:** _____ **WHAT STATES:** _____

OTHER MEANS:

PLEASE ATTACH A WRITTEN EXPLANATION IF NEEDED.

SEAL

SIGNATURE OF PERSON PROVIDING INFORMATION: _____

TITLE: _____ **DATE:** _____

I _____ **AM APPLYING FOR LICENSE TO PRACTICE**
(full name)

PODIATRIC MEDICINE IN NORTH DAKOTA.

SIGNATURE OF APPLICANT: _____ **DATE:** _____