Washington Medical Commission
P.O. Box 47866
Olympia, WA 98504-7866
medical.commission@wmc.wa.gov
360-236-2750

Medical Licensing Board Verification

To be completed by the applicant:

Name of State Medical Board _____

Address _____

_____

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 license 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 above. **All questions must be answered.**

Applicant Name (Print or type)	Birth date (mm/dd/yyyy)
Signature of applicant	

To be completed by the facility/agency/program:

This is to verify that _____ was issued license
Applicant Name (Print or type)

number _____ on _____
(mm/dd/yyyy)

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 the license? ☐ Yes ☐ No

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

Signature _____

Title _____

Email _____

State Medical Board _____

Address _____

_____

Date _____ phone _____

Return to address listed above.