PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

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Certification in Support of Application for Accelerated Temporary Healthcare Licensure by Reciprocity

I, _____, certify to the following:
Name

1) My home address is _____

2) My contact telephone numbers are _____ ***(home)***
_____ ***(work)***
_____ ***(mobile)***.

3) My email address is _____

4) I hold a current license in good standing issued by the _____
Board
of the state of _____, with license number

_____ and have practiced my profession within the last five years.

5) For MDs/DOs, Podiatrists, and Physician Assistants only: I have malpractice insurance. My malpractice insurance carrier is _____ and my policy number is
_____

6) My area of practice specialty (if applicable) is _____

For informational purposes only:

7) I intend to treat patients ☐ in person; ☐ via telemedicine/telehealth (check all that apply)

8) I have the following specialized skills, training, or availability that are relevant during a public health emergency:
_____

_____

By checking this box, I certify to truth and accuracy of the above: ☐

Please send the completed document to NJTempLicense@dca.njoag.gov. Your application will be reviewed and responded to within 24 hours.

PRACTITIONERS AUTHORIZED TO PRACTICE BY ACCELERATED TEMPORARY LICENSURE MUST COMPLY WITH ALL APPLICABLE STATUTES AND RULES.

GO TO YOUR BOARD'S WEBSITE TO VIEW THESE DOCUMENTS.